

Equity in Policy and Health: Examining Inequalities in Job Quality of Caregivers, Refugees' Health Care Access, and the Health Disparity of Health Care Workers in Canada

by

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Author's Declaration

This thesis consists of material all of which I authored or co-authored: see Statement of Contributions included in the thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

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Statement of Contributions

With the exception of Chapter 3, Adam Mursal is the sole author of all chapters in this thesis, written under the supervision of Dr. Weizhen Dong.

Research presented in Chapter 3:

This research was conducted at the University of Waterloo by Adam Mursal under the supervision of Dr. Weizhen Dong. Adam Mursal was responsible for the conceptualization and design of the study; the gathering, review, and analysis of the relevant scholarly literature and of the policy, legal, and media sources examined in the article; the development of the theoretical framework and argument; and the writing of the original manuscript and all subsequent revisions. Dr. Weizhen Dong contributed in a supervisory capacity, providing comments, critical feedback, and editorial suggestions on successive drafts. Both authors approved the final version of the published article. The version presented in Chapter 3 has been revised from the published article to include additional areas of analysis.

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Abstract

This dissertation examines how structural inequities in Canada's health and labour systems shape the well-being and inclusion of marginalized populations, with a focus on the convergence of migration, social policy, and health. Across three chapters, it integrates qualitative, policy, and quantitative analyses to explore how institutions and labour markets perpetuate health disparities among Personal Support Workers (PSWs), refugees, and immigrant or visible minority health care workers. Together, the studies demonstrate ways that systemic inequality, policy design, and institutional neglect sustain vulnerabilities that undermine both population health and workforce stability.

Chapter 2 is a qualitative study that investigates the multidimensional challenges of frontline eldercare work and the job quality of personal support workers (PSWs). The study employs semi-structured interviews with participants who played different roles at eldercare settings (N = 8). The sample included personal support workers (PSWs), Directors of Care (DOCs), and other frontline and supervisory eldercare personnel. Applying the OECD Job Quality Framework, the study finds that PSWs and other eldercare staff experience chronic employment insecurity, emotional exhaustion, and limited institutional recognition. All these conditions worsened during the COVID-19 pandemic. Participants reported heightened physical and psychological strain, severe shortage of staffing, and inequitable workloads, particularly in long-term care facilities. The study highlights how gendered and racialized or visible minority jobs reinforce structural and systemic inequities. The findings of this study suggest that the sustainability of eldercare depends on comprehensive policy reforms that address wages, regulation, and professional recognition.

Chapter 3 is a study that applies social justice theories to critique the equity implications of federal refugee health care policy reforms. It critically assesses the 2012 IFHP cuts, which restricted refugees' access to health care services, and the 2016 reinstatement that only partially restored refugees' health care coverage. The analysis situates these policy shifts within Canada's neoliberal transformation toward market-oriented governance, emphasizing cost containment over social equity. Drawing on migration studies literature, the chapter demonstrates how refugee health care policy operates as a mechanism of "differential inclusion", where societal

status hierarchy (i.e., citizen, claimant, asylum seeker) determines access to care. These exclusions reinforce health inequities among refugees and contravene Canada's stated commitments to health care's universality and health care as human rights. The study concludes that equitable health care access to all is both a social justice imperative and a public health necessity.

Chapter 4 is a quantitative study on health care workers' health disparity in Canada. It utilizes data from the *Survey on Health Care Workers' Experiences During the Pandemic (SHCWEP)* to examine how immigration background and visible minority status are associated with perceived health. Using survey-multivariate logistic regression, the study finds that both immigrant and visible minority health care workers have significantly higher odds of reporting poorer perceived health compared to their non-immigrant, non-visible minority counterparts. Findings reveal that immigrant visible minority health care workers experience the greatest disadvantage. Socioeconomic and age gradients were also observed and were consistent with existing literature. Overall study results demonstrate that systemic inequalities within health care institutions mirror that of broader society, which underscores the need for inclusive policies and targeted supports.

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List of Abbreviations

ADL: Activities of Daily Living

CIHI: Canadian Institute for Health Information

HCW: Health Care Worker

IFHP: Interim Federal Health Program

IME: Immigration Medical Exam

NOC: National Occupational Classification

LTC: Long-term Care

PH: Perceived Health

PMH: Perceived Mental Health

PPE: Personal Protective equipment

PSW: Personal Support Worker

RN or RPN: Registered Nurse or Registered Practical Nurse

SDoH: Social Determinants of Health

SRH: Self-rated Health

Chapter 1: Introduction

1.1 Introduction

Inequality in Canada remains a significant challenge in the sphere of social policy in particular. Canada's official poverty rate reached 10.2% in 2023, with 5.3% of the population experiencing deep income poverty, indicating persistent material deprivation (Employment and Social Development Canada, 2025). These economic disparities translate directly into basic needs insecurity, as 19.1% of Canadians experienced moderate or severe food insecurity in 2023, rising to approximately 25.5% in 2024, equivalent to nearly 10 million people (Employment and Social Development Canada, 2025). Critically, inequities are magnified among those living in poverty, as unmet health care needs rise from 9.4% in the general population to 14.2% among the poor (Dionne & Raymond-Brousseau, 2026). Taken together, these patterns illustrate that poverty in Canada is not only a question of income insufficiency but is deeply embedded in unequal access to essential resources, including necessary health care. Additionally, the COVID-19 pandemic exposed structural inequities embedded within Canada's health and labour systems, amplifying long-standing disparities experienced by immigrants, refugees, and frontline care workers. These inequities are rooted not only in socioeconomic stratification, but also in overlapping processes of racialization, gendered labour segmentation, and inequitable social policy design. This dissertation investigates the relationship between health, inequality, and social policy through three complementary empirical studies. Each addresses a distinct but interconnected manifestation of vulnerability within Canada's health care and societal landscape: (1) the job quality and working conditions of PSWs in Ontario's eldercare sector; (2) the policy inequities embedded in Canada's refugee health care program, the Interim Federal Health Program (IFHP);

and (3) the perceived health status among immigrant and minority health care workers in Canada. Collectively, these chapters reveal how social inequality shapes employment, health care access, and subjective well-being. More specifically, the dissertation advances a single unifying argument across three studies: that labour conditions, migration policy, and institutional arrangements interact to structure unequal health outcomes for Canada's essential and precarious workers, with PSWs' working conditions, refugees' policy-mediated access to health care, and immigrant and visible minority health care workers' perceived health each providing empirical evidence for one link in this shared structural chain. This connection is most direct between Chapters 2 and 4: the chronic understaffing, compressed care routines, and emotional strain that PSWs describe qualitatively in Chapter 2 (Sections 2.5.1, 2.5.3) correspond to the same occupational category, personal support work, the category for which Chapter 4's national survey analysis identifies a health disparity among health care workers (Section 4.6.2), offering convergent qualitative and quantitative evidence of the same underlying social inequality.

Guided by sociological theories on social inequality and the social determinants of health, the dissertation situates case studies of three problem areas within broader debates on health equity: namely, personal support workers' job quality, refugees' health care access, and the determinants of health care workers' health. By integrating qualitative, policy-analysis, and quantitative methodologies, the dissertation provides a multi-level analysis of how macro-level policy frameworks and meso-level workplace structures affect individual health and well-being in Canada's pre- and post-pandemic context.

1.2 Theoretical Frameworks: Social Inequality, Sociology of Health, and Social Policy

The dissertation is informed and positioned within three areas of literature: social inequality, sociology of health, and social policy analysis. Each perspective offers a distinct but also complementary lens for understanding the unequal distribution of health and work in Canada.

1.2.1 Social Inequality and Structural Determinants

The study of health inequality is fundamentally a study of social inequality. From a sociological standpoint, disparities in health outcomes reflect hierarchies of power, resources, and opportunity structured by social class, gender, race, and citizenship, among others (Marmot & Allen, 2020).

The social determinants of health (SDoH) framework theorizes that living and working conditions, such as employment security, income, housing, and social inclusion, are all predictors of health outcomes like morbidity and mortality (Solar & Irwin, 2010; Raphael, 2016).

These social determinants operate within institutional frameworks that distribute risks and benefits unequally among different social groups. Meanwhile, market logic often supersedes social protection and shifts responsibility for health from collective systems to individuals in neoliberal economies where health systems are reorganized around privatization, market competition, cost-containment, and an emphasis on the free market over health as a social right (Sakellariou & Rotarou, 2017).

Throughout the dissertation, inequality and inequities are treated not solely as an outcome, but also as a process across the spheres under study. First, labour-market inequality shapes job quality, income, and exposure to occupational risks. The exploratory study on

personal support workers (PSWs) (Chapter 2) shows elements of feminization of the care workforce, where undervaluation and precarity exist in a highly gendered and racialized or visible minority job sector (St-Amant et al., 2021; Duffy, 2005), shaped in part by immigration patterns and policy regimes that influence who enters care work (including immigrant country dynamics and the age or skill profiles of migrant workers). Second, unfair and unjust social policy manifests through the design and implementation of certain programs, as shown in the IFHP case (Chapter 3). Policy exclusions based on citizenship and immigration status created institutional barriers to refugees' health care access. Third, health inequality emerges as a measurable disparity in outcomes, explored quantitatively in Chapter 4. Lower levels of perceived health among immigrant and visible minority health care workers highlights how overlapping social positions produce unequal experiences of well-being, even within the same profession.

1.2.2 Sociology of Health and Work

The sociology of health provides critical insight into how work and health are mutually important. Employment determines both the source of income and a site of physical and psychosocial exposure. Job quality frameworks, such as the OECD Job Quality Framework, conceptualize work along dimensions of earnings quality (referring to pay workers receive, and how that pay is distributed or translates into material well-being), as well as labour-market security and quality of the working environment (Cazes et al., 2015). Poor working conditions like low pay, high demands, and low autonomy all correlate strongly with adverse health outcomes (Benach et al., 2014).

In Chapter 2, these theoretical principles underpin an exploration of PSWs' job quality during the pandemic. From a sociology of health perspective, PSWs' experiences reveal how macro-level systemic neglect translates into micro-level strain, illustrating the embodiment of inequality through stress, fatigue, and diminished morale (Hapsari et al., 2022). Parallel concerns surface in Chapter 4, where the perceived health of health care workers is examined through analyzing national survey data. This study frames perceived health (PH) within sociological scholarship that treats self-rated health as a meaningful indicator shaped by social and structural conditions (Shields & Shooshtari, 2001). By integrating quantitative data evidence, it extends the argument that health disparities within the health care workforce mirror and reproduce the stratification found in the wider society (Turcotte & Savage, 2020; Gupta and Aitken, 2022).

1.2.3 Migration, Care Work, and the Social Determinants of Health (SDoH)

The social determinants of health (SDoH) perspective outlined in Section 1.2.1, together with the sociology of health and work discussed in Section 1.2.2, provides the primary framework used in this dissertation for understanding how migration and care work converge to produce inequality. Structural determinants, including employment conditions, immigration status, and access to institutional protections, operate cumulatively across the populations examined here. In Canada's eldercare sector, PSWs occupy structurally marginalized positions shaped by overlapping structural determinants, including gendered labour-market segmentation, racialization, and immigration-related precarity (Hapsari et al., 2022); Lightman (2022) documents similar dynamics among Canadian care workers, examining how gender, race, and immigration status combine to shape their working conditions. Their marginalization is reinforced through institutional practices such as limited regulation, wage compression, and exclusion from

professional decision-making. Migration status adds another layer of structural vulnerability. The sociology of migration literature underscores how “differential inclusion” and “citizenship hierarchies” allocate varying degrees of rights and recognition to migrants (Aas, 2011; Baban et al., 2017). As demonstrated in Chapter 3, refugee claimants are subject to shifting policy regimes that alternately include and exclude them from social protections. The IFHP case shows how neoliberal retrenchment and border securitization redefine refugees as conditional subjects of care rather than full rights-bearing individuals.

These social determinants converge within the health care workforce itself. Immigrant and visible minority health care workers, examined in Chapter 4, often experience what researchers have called “segmented incorporation”, which describes how those of immigrant backgrounds often assimilate into essential yet undervalued occupational niches (Lightman, 2022; Lan, 2014). The resulting health outcomes reflect both material exposures and psychosocial stressors associated with discrimination and lack of upward mobility (Denise, 2014; Premji & Shakya, 2017). Thus, the sociology of migration and the social determinants of health (SDoH) collectively help highlight inequality spanning PSWs, refugees, and visible minority and immigrant HCWs - groups that are essential to Canada’s health care system, yet have been positioned at its margins structurally.

1.2.4 Social Policy, Social Justice, and Health Governance

Social policy constitutes the institutional medium through which social values translate into concrete health outcomes. From a social-justice perspective, health policy should aim to achieve equity by addressing systemic barriers and redistributing resources toward disadvantaged populations (Powers & Faden, 2008). Theories of distributive justice, particularly Rawls (1999),

emphasize fairness as equality of opportunity and outcome. Beauchamp (1976) extends this reasoning to public health ethics, proposing that all persons share responsibility for protecting one another from disease and disability.

Chapter 3 applies these normative frameworks to critique Canada's IFHP reforms. The 2012 cuts, which limited refugee access to health care, exemplify policy choices that contravene Rawlsian and public-health ethics by institutionalizing unequal citizenship (Barnes, 2013). The subsequent 2016 restoration addressed some inequities but failed to implement retroactive or structural protections, leaving enduring health disparities. Through this lens, health policy is not merely a technical apparatus but a moral instrument that reflects societal priorities. In broader terms, social policy analysis also explains why frontline workers like PSWs or immigrant and visible minority health care workers (HCWs) encounter systemic neglect. Policies governing labour standards, occupational safety, and professional recognition influence the distribution of risk and reward across the health care workforce. A sociological policy perspective thus links the macro (state policy) to the micro (workers' health), demonstrating how governance decisions shape both access to care and the conditions of caring (Bambra et al., 2020; Raphael, 2016).

1.2.5 Integrative Analysis

Bringing these theoretical frameworks together, this dissertation employs a multi-level analysis by integrating the following: (1) Structural inequality at the macro-level (social policies); (2) Institutional context at the meso-level (workplace organization and professional hierarchy); and (3) Personal experience at the micro-level (perceived health). Each chapter operates primarily at one level while contributing to the whole. Chapter 2 foregrounds the meso-micro dynamics of job quality and emotional labour; Chapter 3 addresses macro-level social policy; and Chapter 4

investigates individual health disparities. Collectively, they form a comprehensive sociological analysis of how structural inequities translate into lived health inequalities in Canada.

1.2.6 Operationalizing the Framework and Key Concepts

The chapters that follow apply the social determinants of health (SDoH) framework at different levels of Solar and Irwin's (2010) structural intermediary model, using analytic tools suited to each chapter's data and research question rather than competing theoretical lenses. Chapter 2 operationalizes SDoH at the meso and micro levels through the OECD Job Quality Framework, which translates structural determinants, earnings, job security, and the psychosocial work environment, into dimensions that can be read directly from PSWs' qualitative accounts of their working conditions. Chapter 3 operationalizes SDoH at the macro, policy level through Rawlsian distributive justice, treating IFHP eligibility rules as an institutional mechanism that allocates the structural determinant of health care access unequally by citizenship status. Chapter 4 operationalizes SDoH at the level of individual outcomes, using immigrant and visible minority status as indicators of structural position and perceived general health as the outcome, consistent with SDoH informed population health surveillance (Solar & Irwin, 2010; Marmot & Allen, 2020). Framed this way, the OECD framework, Rawlsian justice, and the quantitative disparities analysis are not three separate theories in tension with one another; rather, they are chapter specific applications of the same underlying perspective of structural determinants.

Since the three chapters draw on different data sources, an identical operational definition of immigrant, visible minority, or racialized status is neither available nor appropriate across all three. In Chapter 4, both constructs are operationalized using Statistics Canada's survey categories: immigrant status distinguishes non-immigrants from immigrants or non-permanent

residents, and visible minority status follows the Employment Equity Act definition applied by Statistics Canada. In Chapter 2, by contrast, visible minority and immigrant status are based on participants' own self-identification during semi-structured interviews rather than a standardized census category. This is appropriate to the qualitative design, which prioritizes participants' own understanding of their social position over a fixed classification scheme. However, this means Chapter 2's characterization of its sample is not directly commensurable with Chapter 4's population level estimates. In Chapter 3, 'migrant' and 'refugee' refer to legal and policy statuses defined by immigration and refugee law rather than a demographic category measured in a survey. Consequently, the dissertation does not claim that Chapter 2's participants are statistically representative of the immigrant and visible minority health care workers Chapter 4 identifies as being at elevated risk; rather, Chapters 2 and 4 are read as complementary in kind, with Chapter 2 providing in-depth, lived-experience evidence from within the broad social categories, immigrant and racialized or visible minority eldercare workers, that Chapter 4 shows, at a population level, to face a disproportionate share of poor/fair perceived health.

1.3 Contribution of Dissertation

This dissertation contributes to the sociology of health and social policy scholarship in three vital ways.

First, it advances an interdisciplinary understanding of health inequality through evidence across qualitative, policy/content analysis, and quantitative strategies that collectively reveal the stratification of health and health care labour in Canada. The PSW study (Chapter 2) offers an in-depth qualitative account of frontline eldercare workers' experiences during the pandemic, documenting how systemic understaffing, low wages, and lack of recognition affect workers'

mental and physical well-being. The IFHP analysis (Chapter 3) systematically examines the relationship between migration policy and public health, tracing how neoliberal policy reforms construct inequitable access to health care for refugees. The national survey data analysis (Chapter 4) extends this line of inquiry by quantifying disparities in perceived health among HCWs, and finds that immigrant and visible minority status are associated with poorer health among HCWs, offering one of the few post-pandemic assessments of joint-status health disparities in this workforce.

Second, through the integration of perspectives across the sociology of health, migration studies, and social-policy analysis, this dissertation aims to provide a theoretical contribution. Specifically, there is evidence to suggest that the health policy landscape and overall health care workforce function as critical sites of boundary-making where citizenship, gender, and class are negotiated through everyday labour relations, institutional rules, and access to care. By situating PSWs, refugees, and immigrant minority HCWs within a shared analytic frame, the research underscores the continuum of precarity connecting care recipients and care providers alike. This integrative approach contributes to sociological debates on how governments shift the burden of care from public provision to marginalized workers and households, redistributing time, financial costs, and social risks onto those positioned in precarious labour markets (Baines & Armstrong, 2018). In doing so, governments disproportionately rely on migrants and other marginalized groups who are concentrated in low wage care work and who often face additional constraints linked to immigration status and may have limited social protections.

Third, the dissertation informs evidence-based policymaking. Findings illuminate opportunities for reform in three policy domains: (1) improving PSW regulation, wages, and

training; (2) expanding equitable refugee health coverage beyond minimal humanitarian thresholds for admitted refugees, keeping in mind Canada's affordability crisis; and (3) addressing inequities in occupational health and well-being among immigrant and minority HCWs through targeted workplace and provincial policies. The findings of these studies will help policymakers to understand how systemic inequities can be mitigated through inclusive, equity-oriented policy design.

Moreover, by bridging sociological and policy analysis, the dissertation highlights the importance of equity-informed governance and advocates for the systematic integration of social justice considerations into health and labour policies. This contributes to current federal and provincial discussions on workforce planning, health-human-resource retention, and migrant inclusion strategies in post-pandemic Canada.

1.4 Organization of the Dissertation

The dissertation adopts a manuscript-style format consisting of three conceptually connected empirical chapters, preceded by this introduction (Chapter 1) and followed by an integrated conclusion on final thoughts (Chapter 5).

Chapter 2 – *Caring Under Strain: An Exploratory Study of Job Quality and Occupational Challenges Facing Canada's Personal Support Worker (PSW) Workforce* employs a qualitative design to examine how the pandemic reshaped job quality, emotional labour, and occupational identity. Additionally, the PSW occupation was critically analysed using the OECD Job Quality Framework to help shed light on PSWs' experiences within the care sector.

Chapter 3 – *Should Canada Pay for Refugee Health care? A Social Justice Analysis of the Interim Federal Health Program (IFHP)* uses a critical policy-analysis approach to assess the IFHP’s evolution between 2012 and 2016. Drawing on Rawlsian justice and migration-studies perspectives, this study explores how national policy reforms institutionalize health care access inequities against refugees, and how social-justice frameworks can steer more inclusive and equitable social policy making.

Chapter 4 – *Health Disparity Among Health care Workers (HCWs) in Canada: Evidence from the 2022 Survey on Pandemic Experiences* employs national survey data and the tool of logistic regressions to investigate differences in the perceived health (PH) of immigrant and visible minority health care workers. The findings provide empirical evidence of health inequities associated with the joint status of immigration and visible minority background within Canada’s health care workforce.

Finally, Chapter 5 – *Concluding Thoughts* synthesizes insights across all three studies to advance a unified argument, that is, the structural inequities embedded in labour markets, policy systems, and institutional cultures perpetuate health disparities among Canada’s most essential yet marginalized populations. The dissertation concludes with recommendations for multi-level policy reforms that address regulation, equity, and inclusion in the health, health care, and social sectors.

1.5 Conclusion

The COVID-19 pandemic has made visible the deep entanglement between social inequality, health, and policy. By integrating qualitative, policy, and quantitative analyses across distinct but

interconnected case studies, this dissertation provides a multidimensional account of structural vulnerability and resilience in Canada's care and health systems. Ultimately, this dissertation calls for a renewed commitment to equity-oriented policymaking, one that recognizes care work as essential labour, health care access as a human right irrespective of citizenship status, and workers' well-being as a foundation to promoting public health and ensuring a just and inclusive social system in Canada.

Chapter 2: Caring Under Strain: An Exploratory Study of Job Quality and Occupational Challenges Facing Canada's Personal Support Worker (PSW) Workforce

2.1 Introduction

The COVID-19 pandemic has shed light on the existing issues within Canada's eldercare system and has further strained the resources and well-being of both health care professionals and caregivers alike. Specifically, the pandemic brought significant attention and increased importance to Personal Support Workers (PSWs) as an occupation within the health care field. The PSW profession is a critical component of the health care industry, and their services are in high demand (Brookman et al., 2022).

Personal Support Workers (PSWs) are health care professionals who provide support to people with disabilities, the elderly, and patients with chronic and long-term illnesses. The PSW role is responsible for delivering various services, usually to the elderly, which include washing, dressing, feeding, and offering emotional support (Marani et al., 2021). Within the Canadian context, PSWs have been at the forefront of the COVID-19 epidemic, providing crucial care to those who are most at risk to the COVID-19 virus. However, the pandemic has shown that PSWs face a wide range of employment-related challenges, including low job satisfaction, fatigue, and high turnover rates (Hapsari et al., 2022; Pinto et al., 2022). Additionally, 45% of long-term care homes experienced turnover in senior leadership positions, including the Director of Care, Assistant Director of Care, or Administrator positions, with more than 40% indicating difficulties filling shifts for personal support workers and dietary staff (Ontario Long Term Care Association, 2025). Against this backdrop, the present study aims to examine the prevailing condition of the

PSW workforce amidst the COVID-19 crisis, along with an exploration of the factors exerting influence on job satisfaction, burnout, and attrition within this broad occupational group. The aim is to examine how structural inequalities shape the job quality of personal support workers (PSWs) in Canada, using COVID-19 as a critical context that intensified and made visible longstanding conditions of precarity, undervaluation, and constrained labour-market security, as well as to provide an analysis of PSW job quality in eldercare facilities in general.

2.2 Roles, Responsibilities, and Regulation of PSWs in Ontario

Personal Support Workers (PSWs) are an essential component of Ontario's health care system, particularly within long-term care and home care settings. They provide frontline assistance to individuals who require support with daily functioning due to aging, illness, or disability.

Although PSWs are not members of a regulated health profession, they operate under the supervision of regulated professionals, such as Registered Nurses (RNs) and Registered Practical Nurses (RPNs), and follow individualized care plans developed by interprofessional health care teams (Kelly & Bourgeault, 2015). Core responsibilities of PSWs include assisting with activities of daily living (ADLs), such as bathing, grooming, toileting, dressing, feeding, and mobility. They also provide other support, including meal preparation, light housekeeping, and medication reminders; however, PSWs are not permitted to administer medications independently (Baines & Armstrong, 2019).

In addition to personal care, PSWs are responsible for observing and documenting changes in clients' physical or emotional conditions and reporting these observations to supervising staff. This observational function is important in preventing adverse health outcomes and ensuring continuity of care (Saari et al., 2018). PSWs also play a significant role in offering

emotional and psychosocial support. They often develop close relationships with clients, may help to reduce social isolation, and also contribute to a sense of dignity and comfort (Baines & Armstrong, 2019). This relational labour is especially critical in settings such as long-term care homes, where residents may have limited contact with family or community supports. Under specific circumstances and with appropriate training, PSWs may perform delegated clinical tasks, such as non-sterile wound care or catheter care, but only within employer guidelines and in accordance with applicable legislation (Ontario Personal Support Workers Association, 2025). Of note, PSWs are not authorized to independently carry out controlled acts under Ontario law, and are expected to align their work with legislative frameworks.

During the pandemic years, Ontario has strengthened the formal oversight of Personal Support Workers (PSWs) through legislative and regulatory reforms. This includes the establishment of the Health and Supportive Care Providers Oversight Authority (HSCPOA). Beginning on December 1, 2024, PSWs can voluntarily register with the HSCPOA's public registry, which includes a Code of Ethics and processes for complaints, discipline, and appeals (Ontario Hospital Association, 2024). Additionally, the annual report by the Ontario Ministry of Health highlights a significant investment in workforce development, citing over 24,000 new PSWs since 2020 and funding of \$300 million over three years to support training and recruitment (Ontario Newsroom, 2024). The Ontario government also supports rural clinical placement and other rural incentives to address staffing shortages outside urban centres (Ontario Health, 2026). Despite Ontario's evolving regulatory landscape aimed at enhancing the PSW occupation, ongoing challenges remain. The Canadian Institute for Health Information (CIHI) notes that PSW roles remain inconsistently defined, and a national competency framework is still lacking (Canadian Institute for Health Information, 2023). Other recent studies emphasize that

regulation often overlooks key soft skills such as empathy, cultural awareness, and emotional resilience, all of which are qualities essential to effective PSW work (Moudatsou et al., 2020; Shepherd et al., 2019). It is crucial to address these shortcomings to ensure that PSWs are equipped with the necessary skills, competencies, and attributes to deliver high-quality care to those in need.

2.3 Literature Review

2.3.1 Canada's Aging Trends

The demographic transition towards an aging population in Canada has significant implications for health care and social services, particularly in the area of elder care. The average age of Canadians continues to rise, with 17.5% of the population aged 65 or over in 2019, projected to increase to 22.7% by 2030 (Statistics Canada, 2019). By 2036, it is estimated that the number of seniors in Canada will reach 10.8 million, accounting for a quarter of the population (Statistics Canada, 2019). This aging trend poses challenges for the health care system, including quality of care for seniors in long-term care and other eldercare facilities. Studies reveal that many practitioners, including physicians and nurses, feel inadequately prepared to handle the multifaceted needs of older adults, signaling critical gaps in both foundational and ongoing geriatric education (Charles et al., 2014).

Moreover, insights from frontline home care and primary care providers highlight how insufficient geriatric-specific training hampers their ability to deliver high-quality, integrated care to older adults with complex health issues, and suggest that interprofessional geriatric education could help bridge this gap (Ploeg et al., 2017). In addition, the increasing burden placed on caregivers due to the aging population is a critical issue. Approximately 8.1 million Canadians

provided care to family members or friends with long-term health conditions, disabilities, or aging-related needs in 2012 (Statistics Canada, 2013). The role of caregiving can have detrimental effects on caregivers' physical, emotional, and financial well-being, leading to increased stress, decreased quality of life, and adverse health outcomes (Wu et al., 2023; Sadavoy et al., 2022; Li & Lee, 2020). As the population continues to age, the demand for caregivers and the need for PSWs is expected to rise, further straining an already overstretched system.

2.3.2 Eldercare Facilities, Staff, and COVID-19 Pandemic

Nursing homes and long-term care (LTC) facilities in Canada saw disproportionately high COVID-19 death rates, with residents of LTC accounting for 81% of all reported COVID-19 fatalities. Rates in Canada were far above rates in other OECD countries, indicating how significantly the sector was impacted (Akhtar-Danesh et al., 2022). The pandemic also exacerbated staffing shortages, increasing workloads and responsibilities for care staff, which in turn drove high stress and burnout levels, issues well documented in LTC workforce research during COVID-19 (Canadian Institute for Health Information, 2020).

Additionally, the pandemic highlighted critical gaps in infection control within eldercare settings. Many LTC facilities were found to lack robust infection prevention protocols, or the resources to implement them effectively, prompting calls for increased investment in infection control (Canadian Institute for Health Information, 2020). Simultaneously, LTCs faced soaring operational costs, including for personal protective equipment (PPE), sanitation supplies, and staffing, placing further strain on already limited budgets and threatening staffing levels (Canadian Institute for Health Information, 2020).

Finally, mental health among eldercare staff also suffered profoundly during the pandemic. Elevated levels of stress, anxiety, and depression were reported by staff, largely driven by worries about their own and residents' safety as well as inadequate employer support (Canadian Institute for Health Information, 2020). These mental health pressures contributed to increased fatigue and turnover among LTC employees. Elderly residents too faced detrimental effects on their mental well-being, as feelings of loneliness and social isolation significantly intensified due to visitor restrictions and distancing protocols (Smith et al., 2023; Hung et al., 2022).

2.3.3 Personal Support Workers (PSWs) and COVID-19 Impacts

PSWs faced a sharp increase in workload and stress as COVID-19 cases surged. A qualitative study of Ontario PSWs working in long-term care revealed that these frontline workers encountered intensified occupational demands, persistent worries about infection, and few protective resources, which severely impacted their psychological well-being (Panda et al., 2024). Similarly, another study found that PSWs experienced significant workload-related burnout and job stress even before the pandemic, contributing to concerns about care quality (Pinto et al., 2022; Hapsari, 2022). PSWs also reported fear of contracting COVID-19, extended work hours, and staffing shortages, all of which fueled burnout and distress (Panda et al., 2024).

Research showed that job satisfaction declined during the pandemic, aligning with broader findings that health care providers experienced reduced satisfaction under pandemic conditions (Pinto et al., 2022). Mental health was also affected, as PSWs reported high levels of anxiety and depression driven by infection fears and compounded by social stigma and traumatic work experiences. Though PTSD was not explicitly measured, the studies indicated deep

psychological stress (Panda et al., 2024; Hapsari, 2022). Meanwhile, many PSWs reported inadequate infection prevention training, which increased both their own and clients' vulnerability to COVID-19, along with limited to no access to mental health resources, which left PSWs without sufficient emotional support (Pinto et al., 2022).

2.3.4 Personal Support Workers (PSWs): A gendered and immigrant workforce

The PSW workforce in Canada is overwhelmingly female, with many workers belonging to immigrant and racialized or visible minority communities. This is particularly so in Ontario, where approximately 90% of PSWs are women (Hapsari et al., 2022). This aligns with broader trends in the care economy, where women disproportionately fill paid care roles in Canada (Khanam et al., 2022; Canadian Institute for Health Information, 2023). Moreover, care occupations are significantly overrepresented by immigrant workers, with approximately 34% of care workers being immigrants according to the 2016 Census (Khanam et al., 2022). While specific national percentages for PSWs are less available, studies confirm that PSWs in the Greater Toronto Area are predominantly immigrant and racialized or visible minority women (Pinto et al., 2022). In urban centres like Toronto and Vancouver, immigrants from countries such as the Philippines, India, and Caribbean nations constitute a substantial portion of the PSW workforce (Pinto et al., 2022; Khanam et al., 2022). The intersection of gender, race, and immigration status reveals persistent structural inequities as PSWs often encounter precarious employment, low compensation, and limited advancement, all of which are deeply rooted in the historical undervaluation of care work as women's and immigrant labour (Zagrodny and Saks, 2017; Lam et al., 2022).

2.4 Data and Methods

2.4.1 Research Question(s):

The objective of this study is to investigate how the COVID-19 pandemic has reshaped the job quality and working conditions of Personal Support Workers (PSWs) in Ontario, and more broadly, Canada's eldercare sector. Grounded in the OECD Job Quality Framework and informed by a qualitative analysis of semi-structured interviews with PSWs and eldercare staff in Ontario, the study aims to explore how structural labour conditions, gendered and racialized inequalities, and the emotional and physical taxing work together shaped PSWs' frontline experience during the COVID-19 pandemic.

The study is guided by the following central question(s): *How do PSWs describe and make sense of changes to job quality in Canada's eldercare sector during the COVID-19 pandemic, and what structural and occupational factors do they identify as shaping their working conditions, well-being, and perceptions of their jobs during the COVID-19 pandemic?*

To address these questions, the study uses a two-pronged approach. First, the study draws on semi-structured interviews designed to elicit PSWs' detailed reflections on changes to their work during the COVID-19 period. The interview questions explored several key areas related to job quality and occupational transformation, including:

- (1) How has the COVID-19 pandemic affected staffing levels in eldercare facilities?
- (2) How, if at all, have the roles and responsibilities of personal support workers changed since the onset of the COVID-19 pandemic?
- (3) Did the COVID-19 pandemic influence PSWs' job satisfaction and morale? If so, in what ways?

- (4) How, if at all, did the status and public perception of PSWs in Ontario shift during the pandemic?
- (5) What improvements or policy changes do PSWs believe are necessary to strengthen the PSW occupation and the eldercare sector in light of lessons learned from the pandemic?

Second, the study applies the OECD Job Quality Framework as an analytic structure to assess job quality across three dimensions: earnings quality, labour-market security, and quality of the working environment. The purpose of the OECD-informed analysis is to provide an organizing framework for assessing PSW job quality that complements PSWs' individual accounts and links macro-level occupational conditions to micro-level workplace experiences.

2.4.2 Participants

Purposive sampling was used to recruit participants who could provide relevant insights into the research questions. Recruitment focused on individuals with direct knowledge of PSW work in eldercare, including those with firsthand experience as personal support workers or in closely related roles. Potential participants were identified through two main channels. First, online searches were used to identify large organizations operating eldercare facilities across Ontario, including public, private, and non-profit providers, and used publicly available contact information (for example, general facility email addresses, human resources contacts, or publicly listed professional contacts) to circulate a brief recruitment notice describing the study purpose, eligibility criteria, and participation requirements. Second, personal and professional networks were explored to identify individuals who meet the inclusion criteria, and these contacts were invited to recruit their eligible peers.

All participants in the study were employees of eldercare institutions in Ontario during the COVID-19 pandemic. A total of eight participants (N=8) were interviewed between May and July 2023, with each interview lasting approximately 30 minutes to 1 hour.

The majority of the participants identified as female (n=7) and as racialized or visible minority (n=6) (see **Table 1**). Participants' working experiences are from 8 different institutions, and they represented frontline PSWs in both home/community and long-term care, an environmental services worker from a municipal long-term care home, two Directors of Care, a receptionist/triage worker in a long-term care facility, and a social worker serving culturally diverse older adults in the community. For confidentiality, participants are coded as P01, P02, P03, etc.

The number of participants (N=8) can be methodologically justified in qualitative research traditions that prioritize depth, contextual richness, and analytic specificity over numerical representativeness. Adequacy in qualitative sampling is determined by the richness and relevance of the data in relation to the research question rather than adherence to predetermined numerical thresholds (Sandelowski, 1995). The concept of information power further suggests that smaller samples are sufficient when participants possess highly relevant experiential knowledge and when the study aim is narrow and focused (Malterud et al., 2016). Empirical research on saturation supports this position, indicating that thematic saturation in focused qualitative studies with relatively homogeneous samples can be achieved within a relatively small number of interviews, particularly when participants share key characteristics (Hennink et al., 2019).

Additionally, the final sample deliberately included PSW adjacent employees (e.g., Directors of Care, environmental services worker, a receptionist/triage worker, etc.) rather than relying exclusively on PSWs. This choice was made partly, and in some cases primarily, in response to PSWs' structural vulnerability as research participants. Job insecurity, high turnover, and reliance on continued employer goodwill for scheduling and hours create a realistic risk that in-depth interviews about workplace conditions could be experienced as risky to disclose candidly, or could raise a perceived conflict of interest for workers whose employment is itself precarious. Employees in general are recognized in the research ethics literature as a population vulnerable to coercion and undue influence precisely because of this kind of dependency on continued employment, and are owed corresponding safeguards (Resnik, 2016). Qualitative health researchers using key informant approaches have similarly noted that supervisory and adjacent staff can offer substantive insight into frontline working conditions while reducing this risk, provided their selection and power position relative to frontline workers are made transparent (Luetke Lanfer et al., 2024).

Directors of Care and other adjacent eldercare staff included in this study observe PSWs' day-to-day working conditions closely and were, in this sense, well positioned to meet the study's needs regarding the nature of PSW work, while reducing the likelihood that any single frontline PSW's account could be traced back to them by an employer. This approach is consistent with prior Canadian occupational health research on this workforce, which has likewise combined frontline PSW/nurse accounts with key informant perspectives to study sensitive workplace issues such as sickness absence and turnover (Gohar et al., 2020).

Table 1: Participant Characteristics

ID Code	Gender	Visible Minority	Occupation Code	Institution Code
P01	Male	No	Environmental and Food Services Worker	Non-Profit
P02	Female	Yes	Adult Day Program Coordinator	Non-Profit
P03	Female	Yes	Home/Community Care PSW	Private
P04	Female	Yes	Director of Care	Non-Profit
P05	Female	Yes	Receptionist/Triage	Non-Profit
P06	Female	Yes	Home Care PSW	Private
P07	Female	Yes	Director of Care	Private
P08	Female	No	LTC PSW	Private

2.4.3 Data Collection Instrument

This study employed a qualitative research data collection method using semi-structured interviews. The main data collection instrument is an interview guide consisting of open-ended questions. The interview guide was developed prior to data collection to ensure that all relevant topics were addressed while maintaining conversational flow. Follow-up questions were incorporated as needed to clarify participants' responses or to further explore emerging themes during the interviews.

The interview questions include individual experiences, comparing pre-pandemic practices to pandemic-related practices, and the perspectives from each participant's specific role, including those working directly with PSWs (e.g., Director of Care, Environmental Services Worker). This approach enabled more comprehensive accounts and helped increase

understanding of how the COVID-19 pandemic affected the working conditions of Personal Support Workers (PSWs) overall.

2.4.4 Interviews and Data Analysis Tools

Virtual and phone interviews were selected over in-person interviews due to the geographical distribution of participants in Canada, and due to pandemic-related restrictions. Remote interviews were conducted using Zoom or Microsoft Teams based on each participant's personal choice. Microsoft Word and Microsoft Excel were used to code qualitative interview data for themes (see **Table 2**). The interview transcripts were systematically coded through an iterative process that began with the identification of descriptive codes closely reflecting participants' language and experiences. These initial codes were then refined and organized into broader thematic categories that aligned with and extended insights from the existing literature.

Table 2: Qualitative Coding Framework

Overarching Theme	Subtheme (Code)
Workforce Strain and Staffing Disruption Captures accounts of understaffing, increased workload, schedule instability, and related operational disruptions that strain day-to-day care delivery.	Staff Issues
	Burnout
	Staff Shortages
	Staff Turnover
Recognition vs. Reality Identifies discrepancies between public/policy recognition (e.g., “heroes,” bonuses) and participants' reported lived realities of inadequate pay, respect, or working conditions.	Symbolic Praise
	Visibility Without Change
	Lack of Compensation
	Recognition and validation
	Value of PSW

Transformation of PSW Role Flags descriptions of role expansion, task shifting, or scope changes (formal or informal) that alter PSW responsibilities during and after the pandemic.	Infection Control Responsibilities
	Policy Enforcement
	Technology Use
Institutional Support and Gaps Marks references to organizational resources (training, PPE, policies, supervision) and the perceived adequacy or shortcomings of those supports.	Lack of Training
	Leadership Absence
	Strengthened Training
Emotional and Psychological Toll Codes expressions of stress, anxiety, grief, burnout, moral distress, or other mental health impacts tied to work conditions.	Emotional Labour
	Isolation
	Grief and Loss
	Fear and Anxiety
Future-Oriented Recommendations Captures forward-looking views on financial stability, benefits, contract status, career prospects, and employment security for PSWs.	Pay Changes
	Better marketing recruitment
	Mental Health Support
	Comprehensive benefits
	Improved Staff Ratios
	Professionalism and regulation reform

2.4.5 Research Ethics

This study received ethics clearance from the University of Waterloo Research Ethics Board (#22276). For confidentiality, participants' names are coded as P01, P02, P03, etc.

2.4.6 Analytical Framework

To complement and contextualize the qualitative interview data, the OECD framework for assessing job quality was employed to critically evaluate the Personal Support Worker (PSW) occupation within a Canadian context. This multidimensional framework is an internationally recognized instrument that facilitates comparative assessments of occupational characteristics across diverse sectors and geographic regions (Cazes et al., 2015; Garnero et al., 2019). The framework comprises three core dimensions of job quality: Earnings Quality (average wage level and wage distribution across PSW jobs), Labour Market Security (risk of job loss and availability of social safety nets), and Quality of the Working Environment (non-monetary aspects like work conditions, autonomy, workplace relationships). By applying the OECD framework to the PSW occupational group, the study aims to provide a more structured lens to interpret the qualitative findings within a broader context of job quality standards. Furthermore, using the OECD framework allows for benchmarking PSW job quality against broader international standards, thereby supporting evidence-informed policy recommendations aimed at improving PSW work outcomes in Canada.

2.5 Main Findings

The interviews highlight how the COVID-19 pandemic reshaped the work and working conditions of Personal Support Workers (PSWs) across multiple, overlapping domains. Across participants and settings, six major thematic areas emerged:

- (1) Workforce Strain, Turnover, and Staffing Disruptions,
- (2) Transformation of the PSW Role: Infection Control, Policy, Technology Use,
- (3) Psychological Impacts: Fear and Anxiety, Emotional Labour, Grief and Loss

- (4) Lack of Training and Institutional Support
- (5) Recognition, Visibility, and Job Devaluation
- (6) Future of PSW Work: Fair Pay, Professionalization, and Employee Support

2.5.1 Workforce Strain, Turnover, and Staffing Disruptions

Participants indicated a severe staff shortage and cascading workload in the eldercare sector. Across roles and settings, participants described chronic shortages that intensified during outbreaks and isolation rules. The suddenness of the first wave was jarring, particularly in long-term care (LTC), where staffing losses were immediate and steep. This pattern is well documented beyond this study's own sample: personal support workers make up close to three-quarters of Canada's paid home care workforce (Dong, 2022), and the COVID-19 pandemic exposed the severity of staffing shortages across the long-term care sector nationally, with families and informal caregivers increasingly relied upon to fill gaps in paid care capacity (Dong, 2022). Similarly, a Northeastern Ontario study combining frontline PSW and nurse interviews with key-informant perspectives identified staffing shortages and inflexible sick-leave policies as central, recurring drivers of sickness absence and turnover in this workforce (Gohar et al., 2020), corroborating participants' accounts here.

In the first wave, we lost about 40% of our staff almost overnight. Some tested positive, others had to isolate because of exposure, and a few just... didn't show up again. I don't blame them, to be clear. People were scared. There was so much misinformation in the early days. The PPE guidelines kept changing, first it was no masks unless symptomatic, then masks for everyone, then eye protection... it was hard to keep up. — P07

Things got worse as new strains and waves of the COVID-19 virus emerged, when entire departments were severely hollowed out of staff from other areas. For PSWs, shortages translated directly into compressed routines and unmanageable assignments. Care still had to be

delivered, but with less time and fewer hands. During this time, continuity of care depended on a small cadre of available staff who worked relentlessly:

In January of 2022, when I think we were most pressed, we probably had a good half of our work force out of the home sick with COVID having been exposed and forced to remain at home undergoing testing for 10 days so that that December and January of 2021-2022 was perhaps the toughest as far as staffing levels, it was pretty brutal to be honest. — P01

From the staff scheduling desk, the surge felt like an escalation of an old problem rather than a brand-new one, where an emergency layered onto a pre-existing emergency. Overall, the data depict a cascade rather than a single cause for staff shortages. Initial shocks (infection, exposure, isolation) produced capacity deficits; those deficits forced compression of care routines (e.g., one PSW doing “morning routines for almost 10 residents”), which in turn accelerated fatigue, errors, and exits. The reliance on agency staff partially filled visible gaps but created invisible discontinuities (less familiarity with residents, variable training), which frontline workers then had to manage. Staffing issues continue to greatly impact eldercare years after the peak of the pandemic, as one participant recalled:

Staffing has been dramatically affected. Actually, it's very hard to attract and retain staff and this continues to be the case even though the pandemic is ... almost over right? Or this is the new normal ... Staffing is definitely an issue. — P04

2.5.2 Transformation of the PSW Role: Infection Control, Policy, Technology Use

There were significant changes and reshaping of PSW roles during the pandemic. Duties that once fell outside the typical job description became everyday responsibilities. This included an expansion to infection control responsibilities, policy enforcement, and the need to use new technologies in everyday care. One participant described how infection control came to dominate daily routines, overshadowing relational aspects of care:

It almost seemed like routines and resident happiness were almost overshadowed by ... infection control and mitigating transmission and rapid testing and everything. Really just became fixated on the pandemic and I think that the fixation on the pandemic ... kind of took away from some of the lighter, more human aspects between PSW and resident that made the job so lovely in the first place. — P01

Policy enforcement further constrained how workers could respond to resident needs and preferences. PSWs were caught between resident discomfort and organizational rules. Accounts exemplify how policy enforcement, in this instance around the mandatory use of PPEs, somewhat limited PSW autonomy and at times strained their relationships with clients. Participants described the tension when seniors requested more relaxed PPE use, while another mentioned their policy enforcement strategies:

The seniors asked the PSW to take out take off those PPEs and ... but because of the company policy they can't. So it was very, very difficult. — P02

I'm very practical. I will be very strict that they have to do it because it's not only protecting them but protecting the people that they work with. — P05

Technology use was an additional duty that further transformed PSW work. There was an emphasis on automation and digitization where PSW work is increasingly tracked and governed through technological systems as part of infection control and accountability processes.

Participants noted the increased digitization of resident monitoring and reporting:

“I can't remember what the ... system is called but everything was automated, everything was digitized. — P01

Others noted that with families barred from visiting and health care services moving online, PSWs often served as the technological bridge for isolated seniors. In particular, staff found themselves setting up video calls, which were tasks they had rarely done before. These new tech-mediated care duties added cognitive workload and stress, especially for less tech-savvy staff,

but were crucial to maintaining residents' social connections as PSWs were often the only contact point for many residents during lockdowns. One participant noted:

They [PSWs] had to manage technology on top of it all. Coordinating FaceTime calls, troubleshooting iPads, helping residents communicate with family who were panicked and emotional. It was a lot. — P07

These accounts are consistent with published research on Canadian long-term care staff during outbreak conditions: a qualitative study of a Toronto-area LTC home found that frontline staff experienced abrupt, externally imposed changes to daily routines, including new infection-control protocols and technology-mediated family contact, that reshaped care work with little preparation or institutional support (Hung et al., 2022). This corroborates participants' descriptions here of infection control and technology use as imposed, rather than chosen, changes to their day-to-day practice.

2.5.3 Psychological Impacts: Fear and Anxiety, Emotional Labour, Grief and Loss

Fear and Anxiety

Participants repeatedly emphasized how uncertainty around the virus produced persistent fear and anxiety, particularly in the early months. Others described how this chronic fear became normalized as part of daily work. For example, the stress of repeated exposure and testing, combined with the risk of bringing the virus home, meant that PSWs lived in a sustained state of anticipatory anxiety, constantly preparing for the possibility that their clients or themselves would test positive for COVID-19. Early in the pandemic, uncertainty about the virus created a background of constant apprehension. As P01 explained:

When the when the pandemic was very new and we didn't know much about it ... there was just kind of a lot of speculation coming out of organizations like World Health Organization, the CDC ... even our own public health units in Canada and Ontario, we

were just paranoid. We didn't exactly know to a tee how it spread. We didn't know how.
— P01

This lack of clear information, combined with shifting public health guidance, meant staff felt continuously exposed yet never fully protected. However, fear was not only about personal infection but about the possibility of harming family members. Another participant (P03) emphasized that continuing visits to COVID-positive clients felt incompatible with protecting her own household, highlighting how professional obligations and caregiving responsibilities at home were in direct tension:

It was a little bit challenging, because even though when your clients turned to be turn to be Covid positive, we have to do the visit... I have a family I have to come back up, to my place, make sure that my husband and my kids was would be safe. — P03

Participants also linked fear to staffing and workload. In both institutional and community settings, some workers stayed away entirely. As P05 noted, *“They had a lot of work because people will get sick and others will not return to work being afraid of getting sick.”* Fear thus operated as both an emotional burden and a structural driver of staffing shortages, amplifying workload and further undermining job quality for those who remained.

Emotional labour

The emotional labour of absorbing resident distress while simultaneously managing personal distress also emerged as a central feature of PSWs’ experiences. Managers and leadership observed that PSWs were increasingly responsible for emotional support in the absence of families, with employees going above and beyond, transforming the everyday nature of care:

“Staff have really gone above and beyond during the pandemic. Like really? You have people doing all kinds of things. I’ve heard stories of people going out on their on their private time to buy, you know, a type of juice or a type of fruit that a resident may like.
— P04

Of note, additional duties were not accompanied by additional time, resources, or training, heightening the sense of being stretched beyond reasonable limits. Other participants emphasized how emotional connections substitute for family presence. As P08 explained, “*emotionally... we became everything to our residents. Family couldn’t visit, right? So we were the only faces they saw.*” The relational dimension of the job, already central before the pandemic, became more intense and more one-sided, with PSWs carrying residents’ grief, fear, and confusion with limited outlets for their own emotions. Participants framed this emotional labour as both a source of meaning and a key mechanism of strain. Their work reinforced their professional identity and commitment, but it also generated moral pressure to keep working despite risks, and to continue absorbing distress in the absence of organizational supports.

Grief and loss

Grief and loss were pervasive, as PSWs witnessed residents’ deaths under restrictive visitation policies and assumed roles that typically belonged to family members. The absence of formal recognition or debriefing contributed to what participants framed as ongoing trauma where some workers felt responsible for outcomes they could not control. One participant mentioned:

There were a lot of residents who were confused or depressed. And for some who were palliative, they died without their family present. I held one woman’s hand as she passed away. I’ll never forget that. — P08

These accounts of fear, emotional strain, and unacknowledged grief are consistent with survey evidence from Ontario’s long-term care sector: in a study of 227 LTC staff, more than 80% of those working with residents living with dementia reported an increase in moral distress since the start of the pandemic, with over half reporting physical exhaustion and roughly a third reporting persistent sadness, anxiety, or difficulty sleeping, driven in large part by understaffing, visitation

restrictions, and policies staff experienced as harmful (Haslam-Larmer et al., 2023). Similarly, a qualitative study of Ontario PSWs found that intensified occupational demands and persistent infection fears during the pandemic took a substantial toll on workers' psychological well-being (Panda et al., 2024). Taken together with participants' accounts, this evidence suggests that the psychological toll described in this study reflects a broader, well-documented pattern across the sector rather than an isolated experience.

2.5.4 Lack of Training and Institutional Support

Participants described institutional contexts that left PSWs both under-supported and under-prepared, particularly as they navigated the demands of the pandemic. A recurring concern was the arrival of new staff with minimal preparation, which intensified pressure on already exhausted workers. This illustrates a burden where PSWs must maintain high-quality care, while also informally training colleagues, in the absence of structured institutional support. As one participant explained,

There were new hires coming in with almost no training, and that made things harder too. Because you're already tired, and now you have to guide someone else who's still learning. — P06

Additionally, the broader training environment was described as both inconsistent and insufficient. Participants pointed to the steep learning curve and lack of hands-on guidance, particularly for newer workers. Workplace responsibility is framed not only as providing technical training but also as creating mechanisms for feedback and emotional support. One participant emphasized the need for more formalized mentorship and ongoing education, while another mentioned the limited training PSWs receive compared to other health care professions:

There should be more training and support, especially for new PSWs. The learning curve is steep, and many are thrown into the job with very little hands-on guidance. — P06

I just can't imagine that RPN needs ... two years of training and a lot of on the job training, but PSW will just have one or two time[s] of the training. — P02

This is consistent with PSWs' broader regulatory position in Canada, where, unlike nurses and other regulated health professionals, PSWs have historically been unregulated workers whose ongoing professional development is not formally overseen by any licensing or regulatory body (Dong, 2022), leaving training standards and continuing education dependent entirely on individual employers rather than a consistent professional framework.

In several accounts, leadership was perceived as absent or unresponsive, particularly when concerns about quality or safety were raised. For the workers, institutional structures appear more invested in maintaining a pleasant impression than in addressing fundamental issues of safety and cleanliness. Moreover, participants linked the lack of cleanliness to concrete risks in infection control and difficulties in managing COVID-19 outbreaks as many of the temporary and redeployed staff were described as not consistently following protocols. One of the experienced PSW participants noted:

And I remember, too, sometimes temp staff wouldn't follow our protocols properly. Not out of malice, just... they weren't trained the same way. And when every second counts, and you're trying to keep an outbreak under control, even small mistakes feel huge. It was a stressful time for everyone. — P08

2.5.5 Recognition, Visibility, and Job Devaluation

During the pandemic, participants described a complex landscape of recognition where PSWs and other frontline workers were celebrated as heroes. Despite this, PSWs continued to experience structural devaluation. One participant portrayed the early phase of the pandemic as a period of heightened appreciation and symbolic reward:

We were getting a lot of recognition in in society and culture for our efforts. We were called like frontline heroes. A lot of local businesses ... would donate lunch to us, would donate coffee to us. You know, we ... really felt special in ... that first year. — P01

This captures the symbolic praise that temporarily elevated the status of PSWs and helped sustain workers' sense of pride and duty. However, other participants stressed that this recognition was fragile and failed to translate into lasting changes in pay or workplace conditions. One participant described a sharp contrast between early public gratitude and later neglect:

In the beginning, there was this... weird pride, you know? Like, people were calling us essential. Families were saying thank you. I even got a free coffee once from a stranger who saw me in scrubs. That kind of thing makes you feel seen. But that faded quickly. Like, by mid-2021, people had moved on, but we were still dealing with the same chaos ... short staffing, unsafe conditions, long hours. And nothing really changed in terms of pay or respect from the system. — P06

Recognition was also understood through a critical lens that foregrounded gender, race, and immigration status. One participant explicitly linked the persistent undervaluation of PSWs to these overlapping social locations:

I'll be blunt here, it's gendered and racialized. The vast majority of PSWs are women, many are immigrants, and many are women of colour. That plays a role in how the job is perceived and valued, full stop. If you look at nursing, which has its own challenges, there's still a baseline level of recognition. But with PSWs, it's like society assumes this is just 'natural' work for them ... caring, nurturing, cleaning. So they don't see it as skilled labor, even though it absolutely is. — P07

This account ties recognition and compensation directly to broader structures of inequality. In particular, the underlying nature of care work as unskilled labour is seen as reinforcing existing social expectations about women (especially those that are immigrants or racialized or visible minority), and lead to a devaluing of the PSW occupation. This pattern mirrors a broader, internationally documented dynamic in the devaluation of essential work. Stevano (2024),

assessing the ILO's 2023 report on essential work, argues that feminized occupations are classified as low-skilled because the relational and emotional capacities they require fall outside formal definitions of skill, a misrecognition she traces to the broader devaluation of social reproduction rather than to any feature of the work itself.

2.5.6 Future of PSW Work: Fair Pay, Professionalization, and Employee Support

When reflecting on the future of PSW work, participants stressed that meaningful reform must address compensation, benefits, professional recognition, and support. One participant argued for regulated, equitable pay across settings:

I think, uh, I would like to see a regulation ... on how much they [PSWs] get paid ... because it depends where do you work ... because if you work in large facilities you get paid well. — P05

Others emphasized that one time or temporary wage supplements are not sufficient, and do not bring meaningful long-term change. Instead, they called for permanent pay increases and comprehensive benefits that acknowledge the essential nature of PSW work:

First and foremost, we need better pay. I know it's been said before, but I'll say it again. The work we do is essential. We take care of people who cannot care for themselves. That deserves a wage that reflects the emotional and physical demands of the job. And not just temporary pandemic pay ... a real, lasting increase. — P07

Other solutions for the future included more robust training and clearer professional pathways.

One participant described how policies have expanded PSW responsibilities into more clinical tasks, while warning about the lack of sustained support. Finally, one participant underscored the need for focused support for immigrant PSWs, including rights-based orientation and safer reporting pathways:

Support for immigrant workers. Orientation programs that not only teach you how to do the job but also explain your rights, your protections, and what to do if something goes wrong. A lot of us don't know where to go or who to trust. — P07

This call for formal recognition and rights protections aligns with recent regulatory developments in Ontario. The Health and Supportive Care Providers Oversight Authority, a new voluntary registration and oversight body for PSWs, began operating in December 2024, establishing minimum education requirements, a code of ethics, and a complaints process for registered workers (Ontario Hospital Association, 2024). As registration remains voluntary rather than mandatory, however, the extent to which this reform addresses participants' concerns about inconsistent standards and limited institutional accountability remains to be seen.

2.6 OECD Framework: An Analysis of PSW Job Quality

This study applies the OECD Job Quality Framework to examine PSW job quality through three dimensions: earnings quality, labour-market security, and quality of the working environment. The framework is used as an organizing lens that complements participants' accounts and helps connect broader occupational and policy conditions to the day-to-day realities described in the interviews.

2.6.1 Earnings Quality

According to the OECD framework, earnings quality reflects both the average level of earnings and their distribution, capturing how well jobs provide material living standards (Cazes et al., 2015).

Low Wages

For personal support workers (PSWs) in Canada and in Ontario, earnings quality is widely recognized as poor since PSWs are among the lowest paid occupational groups in the health care

sector (Pinto et al., 2022; Hapsari et al., 2022). For instance, a national study described PSWs as the “new precariat,” noting they exhibit features of low wages and economic insecurity (Zagrodney & Saks, 2017). The average hourly wage of Ontario PSWs in home care was only about \$17.30 as of 2020, whereas those in long-term care (LTC) averaged around \$22.69, and PSWs in municipally run nursing homes (with unionized public-sector pay scales) earned approximately \$25 per hour (Pinto et al., 2022). Even the highest-paid PSWs (e.g. in hospitals or municipal LTC) remain modestly paid relative to other health care workers (Pinto et al., 2022). This wage gap signifies that PSW earnings lag behind jobs requiring similar effort or carrying similar social importance. The distribution of earnings is also narrow at the low end, as most PSWs cluster near minimum or slightly above living wage levels, with very limited prospects for substantial wage growth over their careers (Pinto et al., 2022; Zagrodney et al., 2023). In other words, the issue is that virtually all PSWs earn low wages and not necessarily that there is income inequality amongst PSWs.

The Need for Multiple Jobs

Studies show that PSWs often must hold multiple jobs to achieve full-time hours or work overtime in order to attain a living income (Zagrodney et al., 2023). Prior to the COVID-19 pandemic, it was common for Ontario PSWs to work at more than one nursing home or agency. However, this was one of the factors that led to rapid virus spread across facilities, and subsequent emergency orders forced PSWs to choose a single workplace, revealing how their livelihoods depended on combining jobs across sites (Hapsari et al., 2022). The pandemic thus underscored that PSW earnings were insufficient from any one employer, necessitating the need to work more than one job at one or more facilities. It is important to note there have been policy

efforts in Ontario to improve earnings quality for PSWs, recognizing that better pay is crucial for attracting and retaining workers. In Ontario, the provincial government introduced temporary pandemic pay bonuses of \$3/hour for PSWs in LTC and home care, later legislating these increases as permanent (Government of Ontario, 2022). This legislated pay increase was for any eligible PSW working full-time, part-time, and casual, including agency or contracted staff, that worked in any organization with an approved LTC license to operate in Ontario (Ontario Ministry of Long-Term Care, 2022).

Structural and Historical Factors affecting Wages

Key factors relating to earnings quality for PSWs wages remain largely due to structural and historical reasons that existed prior to the COVID-19 pandemic. Long-term care and home care have been chronically underfunded sectors, and the predominantly female, racialized or visible minority, and immigrant PSW workforce has faced systemic undervaluation (Syed, 2020; Zagrodney et al., 2022; Panda et al., 2024). In Ontario, about 90% of PSWs are women and 41% belong to visible minority groups, a demographic profile that some argue has led to care work being underpaid as a result of gender bias in the labour market (Ministry of Long-Term Care, 2020). In addition, the designation of PSW tasks as low skill, despite the considerable skill and emotional labour involved, has long justified their poor compensation (Zagrodney & Saks, 2017). This inequity was acknowledged during COVID-19, when public discourse lauded PSWs as “health care heroes” even as many earned near-poverty wages.

2.6.2 Job Security

The OECD defines labour market security as the combination of low risk of job loss and access to support (e.g. unemployment benefits or stability) in case of job loss, as well as the stability and predictability of work (Cazes et al., 2015).

Most Jobs are Informal Employment

In Canada, PSW jobs remain highly insecure and precarious although the demand for PSWs is very high as the population is aging rapidly. Most PSWs do not enjoy the characteristics of secure employment such as permanent full-time contracts, employment benefits, or trade union protection. Research has found that 86.5% of PSWs were with temporary or casual employment status, and lack of employment benefits (Pinto et al., 2022). Nearly 90% of PSWs had no paid sick days, and about 74% had no extended health benefits through their employer (Pinto et al., 2022). Other studies have found similarly high rates of informal employment, lack of extended health care benefits, and lack of sick days (Syed, 2020; Zagrodney et al., 2022). Indeed, precarious employment is the norm in this occupation (Pinto et al., 2022).

A key aspect of job insecurity is the high prevalence of part-time, casual, and agency work among PSWs. In Ontario's long-term care homes, only about 41% are full-time PSWs, with the remaining workforce being employed in either part-time (roughly 48%) or casual positions (roughly 10.7%), without guaranteed work hours (Ministry of Long-Term Care, 2020). Home care agencies, in particular, rely heavily on scheduling workers on a casual or on-call basis, which are characterized by non-permanent contracts, involuntary hours, on-call work, split shifts, and variable hourly pay (Zeytinoglu et al., 2009). Consequently, PSWs face fluctuating hours and income week to week and may be assigned to different client homes with little

stability. Many PSWs would prefer full-time, stable hours, with research noting that a substantial share of part-time workers would increase their hours if full-time roles were available (Patterson et al., 2023; Baines & Armstrong, 2019).

It Takes Multiple Part-time Jobs to Earn a Full-time Income

Funding and hiring practices have historically limited full-time opportunities for PSWs. As a result, PSWs frequently piece together multiple part-time jobs to approximate a full income, compromising job security and increasing work stress (Armstrong et al., 2009). The COVID-19 pandemic further revealed the insecurity of these arrangements, as emergency regulations restricting PSWs to a single site abruptly eliminated multiple job-holding, causing many to lose one or more positions. This highlights how fragile PSW employment was during the pandemic (Institute for Work & Health, 2025), with many PSWs reporting reduced hours and sudden job loss, sharply elevating their job insecurity (Hapsari et al., 2022).

High Turnover Rates

Another dimension of labour-market security is job tenure and turnover. High turnover rates trouble the PSW workforce, operating both as a cause and consequence of job insecurity.

Precarious working conditions lead many PSWs to leave after short tenures, generating staffing shortages and an unstable work environment. Zeytinoglu et al. (2009) demonstrated that casual employment, including non-permanent contracts, involuntary schedules, and on-call work, was significantly associated with higher turnover intentions among home care workers in Ontario.

More recent data confirm continued instability, where 40.4% of home care PSWs in Canada had been with their current employer for five years or less, with the average job tenure only 6.8 years (Zagrodney et al., 2022). Additionally, government data reveal that approximately 25% of PSWs

in Ontario leave the long-term care sector within two years, and 50% leave within five years, with turnover highest among part-time and casual workers (Ministry of Long-Term Care, 2020). This level of employment precarity deepens labour insecurity for the sector, as limited access to protections such as long-term disability benefits or structured retraining supports can increase the likelihood that job loss results in substantial economic or health-related disruptions for affected workers.

Lack of Trade Union Protection

Job security is also influenced by unionization and regulation. Unfortunately, PSWs have relatively low union coverage overall, except in certain sub-sectors. For example, many hospital PSWs and municipally run long-term care (LTC) home workers are unionized, contributing to their somewhat better wages and job terms (Ministry of Long-Term Care, 2020; Hapsari et al., 2022). However, large portions of the workforce, especially those in privately operated LTC and home care are not unionized, which means PSWs have far less collective bargaining power to secure stable jobs or challenge unjust terminations (Zagrodney & Saks, 2017).

Lack of Professional Regulations

PSWs in Ontario are not a regulated profession with a professional college; they lack the formal professional status and licensing that nurses or social workers have (Kelly & Bourgeault, 2015; Zagrodney et al., 2023). This absence of regulation has historically fragmented the occupation and allowed employers to set variable job standards across different workplaces. No regulatory body exists to ensure standard employment terms or any career ladder for PSWs, leaving workers entirely dependent on each employer's policies for opportunities. In practice, this often means minimal job ladders, few opportunities for promotion or advancement, and a use-it-or-

lose-it turnover model characterized by high attrition, as workers burn out and exit the field in some settings (Ministry of Long-Term Care, 2020; Zagrodney & Saks, 2017).

The overall consequences of low job security for PSWs are severe. From a worker's perspective, the constant threat of losing hours or employment, and the inability to plan one's income or career, contributes to chronic stress and mental health strain. From a health system perspective, insecure PSW jobs lead to staffing shortages and continuity-of-care problems, as experienced staff leave and facilities struggle to recruit replacements. The COVID-19 crisis made it abundantly clear that improving job security is critical for care quality, and for the safety and well-being of both caregivers and those receiving care (Hewko et al., 2015; Ministry of Long-Term Care, 2020). Until such changes take hold, PSWs in Canada will remain emblematic of an insecure workforce, one that is indispensable yet undervalued, in demand yet precarious.

2.6.3 Quality of the Work Environment

The quality of the work environment in the OECD job quality framework refers to non-monetary aspects of jobs, including working conditions, workplace safety, workload, work-life balance, and the psychosocial environment (Cazes et al., 2015).

High Strain Workplaces and Risk of Physical Injury

The work environment of PSWs has been characterized as difficult and often detrimental to health. PSWs provide frontline care, assisting elderly or disabled clients with personal hygiene, feeding, mobility, and other intimate daily tasks that are both physically demanding and emotionally taxing (Kelly & Bourgeault, 2015). In Ontario's long-term care (LTC) homes and home care settings, PSWs typically work in environments of high strain. They care for a large number of patients with complex needs, often under time pressures and without adequate

support. Overall, this results in a work environment marked by high workload, significant physical effort, and exposure to health and safety hazards.

One major concern is the physical strain and risk of injury. PSWs perform repetitive lifting, transferring, and repositioning of clients. These tasks are known to carry a high risk of musculoskeletal disorders. A systematic review of Canadian home care workers found that PSWs face elevated risks of back injuries and chronic pain due to physically demanding caregiving tasks, often conducted without proper ergonomic supports or assistive equipment (Zeytinoglu et al., 2015). These conditions mean musculoskeletal injuries and long-term pain are common, with few opportunities for modified duties or adequate recovery time. In addition, PSWs in home care settings work in varied and sometimes unsafe environments, including cluttered or inaccessible client homes, and this increases the risk of slips, falls, and other injuries (Bagheri et al., 2021; Muramatsu et al., 2018). Beyond physical strain, PSWs also face risks from workplace violence. Multiple studies have reported that PSWs in long-term care facilities frequently encounter physical and verbal aggression from residents with dementia or mental illness, incidents that are often underreported but deeply impact worker well-being (Banerjee et al., 2012; Daly & Szebehely, 2012). Thus, many PSWs work each day under the possibility of being hit, scratched, or verbally threatened by those they care for—hazards that significantly erode their quality of work life.

High Emotional and Mental Strain in the Workplace

Emotional and mental strain are key issues that impact the quality of PSW work environments. Care work is inherently emotional labor. PSWs develop close relationships with clients, witness suffering and decline, and often provide comfort at end-of-life. These psychological demands

can be draining, especially when combined with understaffing that forces workers to rush through care tasks. Research shows that PSWs experience high levels of stress and burnout. Major stressors of the PSW occupation include *repetitive and strenuous tasks, exposure to abuse and violence, and inadequate psychosocial support* on the job (Hignett et al., 2016; Willemse et al., 2012).

Additionally, burnout and mental health issues such as depression and anxiety are increasingly documented among PSWs. A systematic review found a significant association between workplace stressors (like workload and harassment) and mental disorders among PSWs (Chireh et al., 2025). Likewise, another study observed that nearly 47% of PSWs rated their own health as less than “very good”, and higher job precarity was correlated with higher odds of depression (Pinto et al., 2022). The COVID-19 pandemic magnified these challenges, subjecting PSWs to unprecedented trauma. They witnessed high death tolls in their workplace and feared contracting the virus or bringing it home. PSWs were also some of the most likely health workers to be infected with and to die from COVID-19 in Canada, especially during the early phases when personal protective equipment was scarce (Upshaw et al., 2021; Maness et al., 2020). These outcomes underscore the dangerous conditions PSWs endured, often without adequate protection or support, essentially sacrificing personal safety in their work environment.

High Workload and Inadequate Staffing Levels

Workload and staffing levels are also critical components of work environment quality. In many LTC facilities in Ontario, the ratio of PSWs to residents is unreasonable. It has been estimated that one PSW may be responsible for 8–12 residents or more on a shift (Ministry of Long-Term Care, 2020). This means PSWs must rush through tasks like feeding and bathing, with

insufficient per resident time, which can lead to stress due to ethical considerations. PSWs report working under intense time pressures, sometimes needing to rush from one resident to another with little time for breaks. For instance, in a study of Canadian nursing homes, units with poorer work environments showed significantly higher rates of rushed care, highlighting how staffing and time constraints compromise safety and well-being (Song et al., 2020).

A province-wide investigation in Ontario observed that, due to staffing shortages, job duties such as baths are skipped (Ontario Health Coalition, 2020). This emphasized how existing workload pressures force care tasks to be hurried and likely lead to skipping breaks, a dynamic that heightens risk, injury, and chronic fatigue among PSWs. The phrase “assembly-line care” can be said to capture the pace and structure of PSW work, where efficiency often outweighs caregiver well-being or client comfort (Syed et al., 2016; Armstrong et al., 2009). This task-oriented approach not only fragments relational care but imposes stress and diminishes the humanity in caregiving. Moreover, PSWs often lack a voice in care planning or decision-making; as unregulated workers at the bottom of the hierarchy, their insights into patient care may be overlooked by nurses, managers, and other health care staff. This lack of job autonomy and respect can further erode the quality of the work environment, making PSWs feel invisible or disposable within the health care team (Baines & Armstrong, 2019).

2.7 Discussion

The findings of this study highlight that Personal Support Workers (PSWs) in Ontario endured significant challenges across all dimensions of job quality during the COVID-19 pandemic. Both the qualitative interview data and the OECD job quality analysis portray an occupation marked by low earnings, insecure employment, and a strained work environment. Participants

consistently described feeling undervalued and overextended, echoing prior research showing that PSWs earn low wages and face chronically precarious working conditions. In our interviews, PSWs recounted how the pandemic intensified long-standing issues: already-low pay was only temporarily boosted by hazard pay, job instability worsened with high turnover, and daily work became more dangerous and stressful due to the virus. These insights align closely with the OECD framework assessment, which found the PSW role scoring poorly in Earnings Quality, Labour Market Security, and Quality of the Working Environment. By integrating participants' firsthand experiences with this multidimensional framework, the discussion underscores that the COVID-19 crisis did not create these occupational problems so much as it exposed and exacerbated them.

This study confirms that PSWs' earnings remain low, contributing to financial strain. Policy implications here are clear, as there is a need for substantial, sustained wage enhancements and pay equity measures (for example, equalizing PSW wages across sectors) to lift workers out of poverty and acknowledge the true worth of their role. Many participants stressed that livable wages and full-time positions with benefits are foundational to improving job satisfaction and retention. In addition to material adequacy, these wage reforms matter because pay also carries social meaning, signalling which forms of work are institutionally valued and how care is classified within moral and economic boundaries (Zelizer, 1989). Moreover, payments help constitute and regulate social relationships, such that wage-setting practices can shape how PSWs' relationships to employers, institutions, and the people they support are understood and organized (Zelizer, 1996).

Qualitative interviews painted a picture of job instability and staffing crises during the pandemic. Despite PSWs being in high demand, their jobs are typically unstable, with many working part-time or casual positions that offer no guarantee of hours or income. Our results mirror findings from larger studies in Ontario (Zagrodney & Saks, 2017; Pinto et al., 2022; Zagrodney et al., 2023; Hapsari et al., 2022). Workplace hazards were also pervasive even before 2020, with PSWs facing a high risk of musculoskeletal injuries from repetitive lifting and transferring of clients, and they often encounter workplace violence (physical or verbal) from cognitively impaired residents (Zeytinoglu et al., 2015). This staffing precarity carries costs beyond individual workplaces. When paid eldercare capacity is insufficient, part of the care burden shifts to families and informal caregivers, which results in lost productivity and economic costs at a national scale (Dong, 2022). This reinforces that PSW job quality is not merely a workplace-level concern.

Moreover, like other studies within a Canadian context, findings indicate that PSWs feel exhausted, undervalued, and discouraged by low pay, disrespect, and unsafe working conditions. All of these issues are rooted in long-standing structural problems in the eldercare sector (Zeytinoglu et al., 2015; Banerjee et al., 2012). The pandemic acted as a magnifier that brought these issues to the forefront of the social conscience. A positive side effect of this focus was the increased public awareness of PSWs and their critical role in eldercare. However, for true progress, the increased awareness must be translated into action. Elevating PSWs' status within health care teams and society in general will help to improve the overall work environment and professional dignity of the PSW occupation.

Overall, the quality of the work environment for PSWs in Ontario and Canada has been fraught with challenges including high physical demands, safety risks, heavy workloads, and significant emotional stress, all of which are compounded by a sense of being undervalued in the health care system. These conditions not only harm workers (evidenced by high injury rates and burnout) but also threaten the quality of care for patients. Improving job quality in this dimension will require concerted policy action: mandating safer staffing levels, protecting workers from violence, offering supports like paid sick leave and counseling, and fostering a culture that values caregiving work. As the evidence overwhelmingly shows, better working conditions for PSWs lead to improved care outcomes, making it a critical health policy imperative to enhance the quality of the work environment in this occupation.

2.8 Policy Recommendations

Addressing the multifaceted challenges identified above will require comprehensive policy interventions. Based on our findings, several key recommendations emerge to improve PSW job quality and, by extension, eldercare outcomes in Ontario and similar contexts:

- (1) **Improve Compensation:** Substantially raise PSW wages and ensure wage parity across health care settings. Higher pay, coupled with full-time hours and benefits, is critical to attract and retain workers and to signal that society genuinely values their contribution.
- (2) **Enhance Job Security:** Reduce precarious employment by converting casual or part-time roles into permanent full-time positions wherever possible. Implement guaranteed minimum hours and provide benefits like paid sick leave, health insurance, and pension plans to all PSWs, including those in home care, across all types of facilities (public, private, and non-profit).

- (3) **Strengthen Regulation and Training:** Establish a formal regulatory framework or professional college for PSWs. Participants suggested that regulating the profession (similar to nursing) would standardize training, create clear competency requirements, and offer career development pathways. At a minimum, consistent training and certification standards across the province should be enforced.
- (4) **Improve Working Conditions:** Mandate safer staffing ratios in long-term care facilities and home care (e.g. funding to ensure more PSWs per number of residents) to alleviate excessive workload. Mental health supports should also be available, such as counseling services to help offset emotional strain.
- (5) **Include PSWs in Decision-Making:** Policymakers and health care administrators should include PSWs at the table when designing eldercare policies and protocols. Frontline insights from PSWs are invaluable for effective care planning and emergency response.

By implementing these recommendations, policymakers can address both the symptoms and root causes of poor job quality in the PSW sector. Not only would these changes improve PSWs' well-being and job satisfaction, but they would also enhance continuity and quality of care for seniors. Indeed, a central takeaway of this study is that worker conditions are intrinsically linked to care conditions. That is, when PSWs have decent wages, secure jobs, manageable workloads, and a voice in the system, they are better able to provide the compassionate, high-quality care that our aging population deserves.

2.9 Conclusion, Limitations, and Future Areas of Research

2.9.1 Conclusion

This research examined the job quality of Personal Support Workers (PSWs) in Ontario's eldercare sector during the COVID-19 pandemic, using both qualitative interviews and the OECD job quality framework. The results revealed longstanding issues intensified by the COVID-19 crisis. PSWs experienced low wages and financial insecurity, unstable and precarious employment conditions, and highly demanding work environments that took a physical and emotional toll. The pandemic magnified these challenges, from staff shortages and burnout to expanded responsibilities like infection control, all while also temporarily increasing public recognition of PSWs as a vital health care role. The study builds on findings within broader literature and contributes to the understanding of how undervaluation of the PSW workforce has left the eldercare sector ill-prepared for emergencies like the COVID-19 pandemic. In summary, improving PSW job quality is not just a labour issue but a health system imperative. By adopting the policy recommendations like better pay, more secure jobs, and safer workplaces, stakeholders can work towards a more resilient eldercare system.

2.9.2 Limitations

Consistent with its exploratory, in-depth design, this study supports analytic rather than statistical generalization. The interviews were intended to surface the mechanisms and lived experiences shaping PSW job quality, not to produce nationally representative estimates. This constraint is particularly relevant in the Canadian context because health care is administered provincially, and PSWs' working conditions, compensation, and regulatory environments may differ across provinces; which means it is hard to collect all perspectives from other segments of the sector,

including PSWs in municipal-run or other institutional settings. Relevant secondary data and literature are integrated throughout the analysis to contextualize and triangulate the interview findings.

In addition, by comparing patterns across participants and applying the OECD Job Quality Framework as an organizing lens, the analysis documents the processes and experiences specific to this pandemic period. Its findings are therefore best read as time-anchored evidence of how job quality was shaped during this phase, which subsequent phases can build on.

Finally, the study's policy implications should be interpreted in light of broader system constraints. Recommendations such as wage enhancements, improved benefits, and stronger workforce supports must be situated within a health care environment characterized by competing pressures on resources and service capacity, including primary caregiver shortages, long wait times for treatment in some areas, and a wider affordability crisis affecting households (for example, rising food insecurity and food bank use). These contextual realities do not negate the importance of improving PSW job quality, but they underscore that the feasibility and pace of reforms depend not only on fiscal considerations, but also on the practical capacity of health and social systems to implement and sustain changes alongside other urgent demands.

2.9.3 Future Areas of Research

Future research should build on these findings to further explore and address PSW job quality. A priority is to conduct large-scale mixed-methods studies to confirm the prevalence of issues like precarious employment, burnout, and low pay across different regions and sub-sectors of eldercare. Comparative studies between provinces (or countries) could shed light on how varying policies affect PSW outcomes, identifying best practices. Longitudinal research would also be

valuable: following PSWs over time (for instance, post-pandemic) could reveal whether recent policy changes, such as permanent wage increases or staffing ratio mandates, are improving job quality and retention, or if challenges persist. By addressing these avenues, research can continue to inform evidence-based policies that elevate the PSW profession and ensure high-quality care for aging populations in the years ahead.

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Chapter 3: Should Canada Pay for Refugee Health Care? A Social Justice Analysis of the Interim Federal Health Program (IFHP)

3.1 Introduction

The global refugee crisis has been a great challenge to many countries' health care system and beyond. In 2015, an estimated 65.3 million people worldwide were considered displaced peoples, including 21.3 million refugees (The UN Refugee Agency, 2025). Such large-scale global migration has implications for both public health and population health, requiring a comprehensive response from governments using national policies. The number of resettled refugees arriving in Canada as part of the Government of Canada's refugee resettlement program increased by almost 55.7%, from 12,875 persons in 2014 to 20,415 persons in 2015 (Immigration, Refugees and Citizenship Canada, 2017). This trend is expected to continue, as Canada admitted 51,081 resettled refugees in 2023 and 49,285 in 2024, and the 2026 to 2028 Immigration Levels Plan targets 49,300 admissions under Refugees and Protected Persons in 2026 (Immigration, Refugees and Citizenship Canada, 2024, 2025a, 2025b). Recent research on refugee health status has 'found a notable burden of chronic diseases among refugee patients, including anemia, elevated BP, and impaired glycemic control, as well as abnormal cervical cytology findings' (Redditt et al., 2015).

Due to refugees' exclusionary status as non-citizens, they are subject to a variety of factors that contribute to poor health outcomes, including financial struggles, poor health status, invasive security measures, and human rights limitations. Refugees frequently live in overcrowded and unsanitary conditions, where access to sufficient food, clean water, and

protection from environmental elements such as heat, cold, and rain is limited, leading to adverse health outcomes (Caxaj et al., 2024; Kaur et al., 2021).

Prior research on national policy cuts to immigration programmes has focused on health care worker perspectives, Canadian charter/rights violations, refugee or migrant access to health care or other social services, and existing legal challenges related to reforms introduced by the Conservative government in 2012. No attempt has been made to ascertain how shifts in national policies have established inequities that cause health disparities among refugees within the context of population health. This paper aims to evaluate the potential for existing inequities, inequalities, and/or injustices present within policy reforms. Based on social justice perspectives, we argue for the expansion to the IFHP that goes beyond the restoration of benefits seen in 2016. Specifically, given the health disparities faced by refugee groups, there is a need to expand health care coverage for the benefit of Canada's overall population health. A comprehensive approach is used to develop a framework for understanding the impacts of national policies in creating health disparities, with specific attention to refugees.

This review utilizes background information on the Interim Federal Health Program (IFHP) and employs theoretical concepts from social justice perspectives and migration studies to identify problems relating to refugee inequities. The aim is to explore and discuss the impact of the IFHP reforms (2012, 2016) on overall refugee health and access to health care services.

3.2 A History of Refugee Health in Canada

Canada has continually experienced high rates of immigration following national independence, with a considerable number of refugees resettled in Canada following WWII. This trend

persisted throughout the Cold War and the duration of the 20th century, when Canada accepted thousands of refugees annually, reaching a high of over 60,000 in 1979–1980 (Roseborough & Hudson, 2020). However, bias within refugee policies has resulted in the exclusion of those with disabilities, mental health struggles, or contagious diseases. Health status became a criterion for evaluating refugees, preventing many from receiving or accessing necessary health treatments (Holtzer et al., 2017). Health admission rules discriminated against refugees with impairments and diseases for which they were at a greater risk due to their frequent flight from war-torn nations (Roseborough & Hudson, 2020). These laws effectively barred many persons in need of health care services from entering Canada.

The Canadian government recognised the need to address refugees' health care requirements in order for them to effectively establish themselves in Canada. In 1957, Canada enacted legislation that would eventually become the Interim Federal Health Plan (IFHP), which covered immigrants' first post-arrival medical treatment while they negotiated the application processes necessary to get provincial coverage (Abdihalim, 2016). The IFHP was founded on the principle of providing refugees with medical treatment equivalent to what a Canadian would receive, understanding that maintaining good health was critical to successful integration into Canada (Antonipillai et al., 2017). The IFHP was developed concurrently with the federal Hospital Insurance and Diagnostic Services Act, which covered provincial health insurance impacting all Canadians and laid the groundwork for the Canada Health Act (Turner, 1958).

3.3 Methodological Approach

This chapter is best characterized as a theoretically critical policy analysis. The central guiding research question is as follows: *How have the 2012 and 2016 reforms to the Interim Federal*

Health Program (IFHP) shaped health inequities and health disparities among refugees in Canada? This research question guides a purposive review and interpretation of policy documents, legal decisions, and existing research relating to the IFHP. The focus is on the following themes: the existence of differential inclusion and resulting refugee sorting, widespread security and surveillance measures directed at refugees, the mass collection of biometric data from refugee groups for screening purposes, the prevalence of barriers for refugee access to health care and other social services, and the potential for increased health care disparities due to current national policies. The analytic process involved a critical, thematic policy analysis, whereby reviewed materials were organized around the guiding research question and interpreted through migration and social justice frameworks.

The evidence base comprises three overlapping bodies of material:

- (1) primary policy and legal documents describing the design and reform of the IFHP, including Immigration, Refugees and Citizenship Canada program materials, federal Orders-in-Council and budget announcements, and judicial decisions concerning the 2012 reforms, most notably *Canadian Doctors for Refugee Care v. Canada (Attorney General)*, 2014 FC 651;
- (2) peer-reviewed literature on refugee and migrant health, health policy, and migration studies, addressing both the empirical consequences of the 2012 and 2016 reforms and the conceptual vocabulary, such as differential inclusion and citizenship hierarchies, used to interpret them; and,

(3) normative literature in political philosophy and public-health ethics, principally Rawlsian distributive justice, used as an interpretive lens rather than as an empirically testable model.

Sources were selected purposively rather than through a systematic search protocol. Government and legal documents were included where they directly describe the scope, eligibility criteria, or legislative history of the IFHP between 2012 and 2016. Academic literature was prioritized where it addressed the IFHP specifically or the theoretical frameworks applied in this chapter, namely Rawlsian justice and differential inclusion. In addition, broader migration literature was used to situate the Canadian case within wider patterns.

3.4 Overview of National Policies

3.4.1 Review of the Interim Federal Health Program (IFHP)

The IFHP is a federal health programme that provides limited, short-term health care coverage for resettled refugees, asylum claimants, rejected claimants, detainees, victims of human trafficking, and other protected status individuals (Citizenship and Immigration Canada, 2021). Eligibility and length of coverage depend on current group status. For example, a refugee claimant is entitled to coverage until he or she ‘leaves Canada or becomes eligible for provincial or territorial health insurance’ (Citizenship and Immigration Canada, 2016a). Individuals entitled to some level of health care coverage under public or private insurance schemes are not eligible for the IFHP. The health care services that are covered include basic medical treatment, supplementary coverage (such as limited vision and emergency dental care), and prescription drugs. The programme also covers the cost of a comprehensive diagnostic exam under the *Immigration and Refugee Protection Act*, referred to as the **Immigration Medical Exam (IME)**.

This exam includes a physical and mental examination, a review of medical history, lab tests, and a final inclusive physician assessment. The IME is a requirement for all migrants (with few exemptions), including refugees. See **Table 3** for further program details.

Table 3: Summary of Interim Federal Health Program coverage in Canada

Included Coverage	Description of Coverage
Basic Coverage	• in-patient and out-patient hospital services • services from medical doctors, registered nurses, and other health-care professionals licensed in Canada, including pre- and post-natal care • laboratory, diagnostic, and ambulance services
Supplemental Coverage	• limited vision and urgent dental care • home care and long-term care • services from allied health-care practitioners including clinical psychologists, psychotherapists, counseling therapists, occupational therapists, speech-language therapists, physiotherapists • assistive devices, medical supplies/equipment, including: ◦ orthopedic and prosthetic equipment, mobility aids, hearing aids, diabetic supplies, incontinence supplies, oxygen equipment
Prescription drug Coverage	• prescription medications and other products listed on provincial/territorial public drug plan formularies
Coverage for Immigration Medical Exam (IME)	• covers the cost of one IME and IME-related diagnostic tests required under the Immigration and Refugee Protection Act
Pre-Departure Medical Services	• vaccinations • outbreak management and control • medical support needed for safe travel

Note. Data are from Government of Canada (2021).

3.4.2 IFHP Reforms: 2012 (Reducing Coverage) and 2016 (Restoring Coverage)

In 2012, modifications were made to the IFHP that reduced coverage for most refugees. Key changes include the removal of supplementary health coverage for some refugees based on their asylum category, as well as limiting the programme to basic or emergency health services.

Despite these changes, the IFHP would continue to cover immunization efforts should the public health of Canadians be at risk. These changes have led to a variety of undesirable and adverse outcomes. Consequences as a direct result of the 2012 cuts involve increased difficulty for refugees and asylum seekers to access health care in Canada; the complete elimination of health care for claimants in certain refugee classifications; increased use of hospital emergency room (ER) services by refugees, thus further aggravating already long ER wait times; increased health risks for women and children refugees due to medical support barriers; and increased incidence of chronic illness among already unprotected refugee populations (Barnes, 2013). The administration's stated objectives for the change include a desire to meet Canada's economic needs, prevent widespread abuse of the programme, dissuade fictitious refugee and asylum applications, ensure fairness, and reduce the tax burden on Canadians (Government of Canada, 2012).

Following amendments introduced by the new Liberal government on April 1st, 2016, most (if not all) areas of reduced health coverage have been restored. In particular, the IFHP now extends health care coverage (including basic, supplementary, and drug coverage) to all eligible beneficiaries, and does not discriminate based on group status. In addition, the changes include coverage for services that extend to refugees prior to arriving on Canadian soil, such as 'pre-departure vaccinations, services to manage disease outbreaks in refugee camps, and medical

supports during travel to Canada’ (Citizenship and Immigration Canada, 2016b). However, a cause for concern is that the reinstatement of benefits is not retroactive, resulting in potential health care access disparities amongst refugees depending on their date of entry. Additionally, the lack of retroactive benefits means that refugee claimants who entered Canada or applied for asylum between 2012 and 2016 will be denied access to IFHP-covered health services. Proposed advantages of increasing the scope of coverage relate to improving the overall health status of refugees, protecting the public health interests of Canadians, decreasing the administrative burden on health care workers delivering services to refugees, and reducing the provincial and territorial burden of refugee health care expenditure.

3.4.3 Market Orientation

To review refugee health and existing inequities, this section explores the market-oriented perspective within a Canadian policy framework, and with direct attention to Canada’s historical roots.

A market-oriented model is an individualist approach to policy that focuses on ‘individual responsibility, minimal collective action and freedom from collective obligations except to respect other persons’ fundamental right’ (Beauchamp, 1976). From an economic standpoint, this is the dominant model internationally; it uses the laws of business, market economies, and supply and demand as a foundation, with a focus on the fairness of opportunity and little emphasis on equality of outcome. Regarding health, the model has certain benefits, such as increasing competition between health service providers and industries, enhancing the efficiency and satisfaction of health care delivery, developing consumer-driven health care options, and reducing public expenditure on health care (Matthews, 2014). Despite these

benefits, the approach carries serious concerns from a social justice perspective. Shortcomings involve shifting primary responsibility for health and disease to the individual, ignoring the social determinants of health and the collective nature of death or disease, failing to limit voluntary action that harms the common good (e.g. smoking), overemphasizing medical technologies and interventions, and disregarding the importance of preventative public health.

Market orientation contrasts heavily with Canada's historical stance on immigration and health care policy, as Canada is known for embracing diversity and promoting multiculturalism. Toronto was recently named the most diverse city in the world based on the proportion of foreign-born residents (51%) and diversity of ethnicities (Marche, 2016). Under the Canada Health Act, all residents of Canada are entitled to reasonable access to medically necessary hospital and physician services without direct out-of-pocket costs, in accordance with the principles of comprehensiveness, universality, portability, and accessibility (Government of Canada, 2023). From this definition, the spirit of Canada's federal policy falls within the realm of a social-justice framework, as 'all persons are entitled equally to key ends such as health protection' (Beauchamp, 1976). This argument renders the adoption of highly discriminatory policies such as the 2012 IFHP reforms particularly alarming and leads to the following questions: whose interests are served, and who benefits most from market-oriented policies negatively affecting refugees? Such critical questions must be considered when governments suggest or execute significant cuts to health programs for vulnerable populations, particularly refugees.

3.5 Refugee Health Inequities – Social Justice Perspectives

3.5.1 Rawls' Theory of Justice

In *A Theory of Justice*, John Rawls (1999) articulates a framework of social justice. According to Rawls, for a society to be just, it must have the following basic principles: 'equal citizenship status and political liberties, freedom of thought, equal opportunity (including access to education and culture), free choice of occupation, and a guaranteed Social Minimum or living standard' (Shield, 2013). These principles are best clarified using the veil of ignorance, a test which Rawls developed to evaluate the fairness of a chosen society. Rawls states, 'no one knows his place in society, his class position or social status; nor does he know his fortune in the distribution of natural assets and abilities, his intelligence and strength, and the like' (Rawls, 1999, p. 118). In plain words, the veil of ignorance stipulates that a society is just only when all members receive a fair distribution of resources required for a decent life despite social, economic, physical, psychological, or other conditions that may affect quality of life. Rawls also discussed the distinction between a market system and a legislative body – the former being concerned with efficiency as its outcome, and the latter being concerned with justice as an outcome. Rules ensuring equal opportunity are not entirely just by themselves; they must be accompanied by equality of outcome.

Rawlsian theory can be applied to analyse the fairness of federal policies, including the 2012 IFHP reforms. It is important to evaluate federal policy with respect to vulnerable populations, specifically refugees and asylum seekers. First, it is essential to identify the unique challenges of the refugee population to inform our analysis of unequal policies. Issues include discrimination due to displaced peoples status; poor scoring on all metrics of human

development, including health; and systemic barriers to accessing social or public goods often available to citizens of a nation or those with similar legal status. Unlike economic immigrants, refugees often face additional problems. Thus, under the Rawlsian framework, providing health care services to asylum seekers is a requirement to ensure equality of outcome.

The 2012 reforms stand in direct conflict with the just society envisioned by Rawls. The changes were intended to save Canadian tax dollars, reduce bogus refugee claims, and ensure that refugees did not have access to health care services deemed equivalent to (or better than) those of Canadian residents. A 2013 Health Equity Impact Assessment found that the 2012 IFHP reforms would ‘make accessing even basic health care services difficult for all refugees and refugee claimants, even those who are in the preferred categories such as government-assisted refugees; ... put women and children at particular risk, as their access to medical support, if they suffer physical or emotional abuse, would be eliminated; and increase the prevalence of chronic conditions, such as mental health issues, among vulnerable populations’ (Barnes, 2013).

The impact assessment was prepared by the Wellesley Institute based on predictions that changes to the IFHP that removed health coverage would have a detrimental impact on refugee health, with disproportionate impacts to refugee women and children. Data for the impact assessment was obtained from health care professionals throughout Canada via online reporting in order to study the health impacts to refugee populations following modifications to the IFHP in 2012. Of note, the Wellesley Institute applied an equity lens and supported the need for equity in policy development outside the health system. Under an equity lens, elements like poor housing, low income, and low education are thought to have detrimental effects on the population as a whole, but more so for vulnerable or disadvantaged communities. It is critical,

then, to consider health equity when developing policy that may have an effect on the health determinants of refugee groups.

This review tackles the issue of cost savings. According to Beauchamp, ‘all persons are equally responsible for sharing the burdens—as well as the benefits—of protection against death and disability’ (Beauchamp, 1976). Following this thought process, it can be argued that all Canadians are responsible for providing some level of assistance to refugee claimants, and it would not be a stretch to allocate some resources and tax dollars towards this mandate. However, the 2012 reforms pushed for fiscal responsibility and argued that it is not Canada’s ethical responsibility to provide services exceeding necessary or vital emergency care. If the real goal is to save public resources, making cuts to the programme is counterintuitive. According to the Wellesley Institute, the 2012 IFHP cuts lead to ‘increased numbers of refugees and refugee claimants arriving in emergency rooms for reasons that could have been avoided, adding to already long wait times’ (Barnes, 2013). This not only contributed to diminishing the quality and responsiveness of our current health care system, but also caused an increase in health-related costs for provinces and territories to fill the gap in refugee health care.

Since cuts to the IFHP were reinstated in 2016, refugee access to health care is similar to that of low-income Canadians. Critics argue that this is particularly unjust, as refugees may now have better overall access to health services than Canadians who do not qualify as low-income individuals. For instance, although basic dental and vision care is provided to refugees under the IFHP, it is an out-of-pocket expense for most Canadians. To fairly evaluate this perspective, the *vulnerability* of refugee groups must be realized. The distinct challenges faced by refugees should mandate the provision of policies that aim to level the playing field, rather than increase

the possibility for negative health outcomes. Rawlsian theory suggests that policy reforms should go beyond the 2016 reinstatement of benefits, and instead push for changes that target refugee-specific health concerns. More importantly, disallowing health care services will eventually be a greater detriment to Canada's population health, should refugee claimants eventually become Canadian citizens.

3.6 Refugee Health Inequities – Migration Studies Perspectives

3.6.1 Using Status to Determine Health Care Eligibility

The concept of the 'other' encompasses groups that do not fit neatly into the common definition of a citizen. Those designated as 'other' include an array of diverse groups, such as accepted refugee claimants, refugee claimants awaiting application status, asylum seekers whose refugee claim has been denied, detained individuals, victims of human trafficking, and permanent residents. Baban et al. in 2016 studied changing citizenship structures in a globalizing world, whereby 'multiple pathways to precarity, differential inclusion, and negotiated citizenship status' became the norm for Syrian refugees in Turkey. The article provides evidence of the existing use of hierarchical citizenship, a process that leads to the marginalization of certain groups, creates novel social partitions, and promotes new and unequal pathways to status acquisition.

The theory of differential inclusion and related migrant sorting is echoed by Katja Aas in a 2011 study, *'Crimmigrant' bodies and bona fide travelers: Surveillance, citizenship, and global governance*, which illustrates the existence of 'unequal positions held by various social groups in terms of their subjection to surveillance: citizens, subcitizens, supracitizens, and non-citizens' (343). This hierarchy of social stratification, brought forth through the logics of citizenship, contributes to a spectrum of social inequality where, on the one hand, some groups

enjoy high mobility and increased social benefits and, on the other hand, some groups face a loss of rights, extreme resource scarcity, and limited social opportunities (Aas, 2011).

3.6.2 Borders as Barriers to Access and Protecting Canadian Health Resources

Security and access concerns stem directly from the issue of migrant sorting and classification. With fewer rights in comparison to full citizens of a nation-state, refugees are subject to border security measures and associated barriers in a variety of global and local settings. As previously mentioned, the reason frequently cited by governing bodies relates to the protection of Canada's public health interests and health care resources. In other words, borders and barriers to health care access are necessary to prevent access to coveted national services (e.g., Canada's health care system), and to effectively deny access to individuals who are deemed ineligible. The use of the term border security here is broad in nature, where 'border' is understood as a dispositive of security (i.e., a rationale or logic of security). In this sense, border logic embodies far more than the traditional or common definition (limited to physical borders) and instead transcends spatial and temporal domains. As such, the rationale of border security is synonymous with a barrier or firewall, where certain groups are either granted or denied access based on status. Following this logic, the border security rationale can be applied to domestic populations and used to limit access to social resources, such as health care.

Applied to refugee health care in Canada, border security logic is employed as a discrete modification to the IFHP. In public and on paper, the Conservative administration, which held power during the 2012 IFHP reforms, mentioned fiscal responsibility as the main motive for the proposed changes. This myth was debunked following a case presented before the Federal Court of Canada (Chan et al., 2014). Using the rationale of border security, we can reframe IFHP cuts

as a means to protect Canada's health care resources through the overt denial of health care access to outsiders. These policy changes are founded on anti-immigration sentiments and a need to securitize migrant groups; both are political positions that run contrary to Canada's image as a multicultural polity. The anti-immigration position of the Conservative government was clear and borders on racially divisive or discriminatory. The evidence to support this argument rests in the record of policies introduced by the Conservative administration in and around 2012. This includes measures such as requiring biometric fingerprinting for refugee claimants and running those prints against multiple criminal databases, replacing a former skilled worker selection model with an employer-driven process that enables employers to select candidates from an applicant pool, and tightening rules and administrative procedures related to conditional status and spousal sponsorship (Livingstone, 2013).

Moreover, the federal Conservative government framed the IFHP reforms as part of a broader agenda of immigration system "transformation" that, at the time, emphasized admissions that were more responsive to labour market economics, alongside heightened attention to program integrity and expedited refugee determinations. In this framing, restricting health care coverage for some refugee claimants functioned as a symbolic and administrative tool to reinforce a security and deterrence orientation within the refugee program area, while remaining compatible with Government of Canada commitments to multicultural nation-building in other areas of immigration policy. Specifically, these policy changes constructed a process whereby non-citizens (or the 'others') of Canada were subject to additional layers of security when accessing health care, such as self-identifying and providing proof of status when accessing health care services. Without basic health care coverage or the resources to pay for access to clinics, many physicians and other health care professionals urged refugees to seek care in

hospital ERs where they were less likely to be denied care (Stall, 2012). Despite the adverse consequences discussed above, the Conservative government framed the IFHP reforms using the positive vernacular of cost savings to Canadian taxpayers and the ability to deny health care services to “bogus refugees” and reduce “bogus claims” (Macleans, 2015; The Canadian Press, 2012a). Additionally, the significant financial and political strains on the Canadian health care system may have prompted the Conservative government to restrict health care services to refugees.

3.6.3 Refugee Screening, Biometrics, and Health Status

The health status and health outcome of refugees entering Canada is a crucial domain of study for the exploration and discovery of existing governing strategies. In particular, we must review any existing policies that limit refugee entry and subject asylum seekers to increased health screening. Commonly stated objectives for any type of security measure often relate to protecting public safety. As the focus of this paper is on health, this translates to the protection of Canada’s public health interests. This section of the paper provides a brief background on refugee health care needs and prevalent health concerns, analyses existing IFHP policies with reference to biometric use in Canada, and provides an argument for how refugee health is securitized for the filtration of asylum seekers based on health status.

In Canada, automated biometric techniques (defined as the collection of individual biological information, such as fingerprints or iris scans) are used to identify and manage refugee populations. According to Rygiel, the effect of biometrics and related identification systems ‘is that they attempt to divide and classify people into social groups’ (Rygiel, 2010, p. 119). The use of biometric data has become almost synonymous with the concept of identity. More notably,

biometric identification systems remain discriminatory (p. 155). The requirement of the IME by Citizenship and Immigration Canada (CIC) provides a prime illustration of biometric data and associated discriminatory practices. The IME is a tool used to pre-screen the health status of refugee claimants.

As mentioned previously, the IME involves a variety of health tests (physical or mental exam, review of medical history, lab or diagnostic tests, and a cumulative medical evaluation) that lead to the formation of health risk profiles. All permanent residents, temporary residents, and refugees are required to submit to the IME, which is typically performed by panel physicians in Canada or designated medical practitioners who hold membership with CIC. The results of the IME are submitted to a Regional Medical Office and remain valid for a 12-month period.

The use of biometric measures such as the IME to screen the health of refugee claimants causes an additional layer of discriminatory practices. According to CIC, the results of the IME may be used to impose conditions on visa applications as well as deny refugee applications based on health status. If the health condition of a refugee ‘is likely to be a danger to public health or public safety, or might reasonably be expected to cause excessive demand on health care or social services’ (Citizenship and Immigration Canada, 2013), then the government is legally justified in denying asylum claims.

With reference to diseases carrying strong social stigma or a high burden of health care costs (e.g. HIV/AIDs), additional measures and stringent assessments are required as part of the IME and refugee application. Moreover, the IME appropriates results from a variety of biometric tests to create health risk profiles. Through these profiles, governments form data banks containing a variety of biometric identifiers; this leads to a dangerous scenario whereby myriad

security and surveillance projects can be applied to refugees, even following their attainment of Canadian citizenship.

3.7 Implications of Inequities within National Policies

This section focuses on the identifiable refugee implications caused by inequitable federal policies, with special attention directed towards the presence of health inequalities. The effect of IFHP policy reforms on refugee health and well-being, the presence of systemic inequities that cause negative health outcomes for asylum seekers, and the consequences for Canada's health care system and overall population health are specifically reviewed.

The primary concern with the IFHP reforms involves reduced health care access for refugee populations and the increased presence of barriers. The 2016 reforms do not address the non-availability of translation services, cultural competency in health care related to differences in understanding the scope of disease, or differences in social interaction and related information exchange. Many health care providers lack sufficient knowledge of refugee health care entitlements. For example, a 'man with a rectal mass was turned away from care many times although he should have health insurance according to the IFH policy' (Barnes, 2013).

Refugees also have immense difficulty navigating Canada's diverse health care system. Due to language barriers, many refugees are not aware that they are entitled to certain health care benefits. Language also contributes to unfamiliarity with health service procedures, such as how certain health concerns are properly addressed. The 2016 reforms also contain a large systemic barrier that furthers inequality. The reinstatement of benefits was not retroactive; refugee claimants who filed for status in Canada between the four-year period of 2012–2016 are not

eligible for the comprehensive health care services provided under the 2016 reforms (Citizenship and Immigration Canada, 2016b).

Although the government did not provide an official explanation for why benefits were not made retroactive, some commentators suggested several contributing factors. These included the view that the reinstated IFHP remained affected by a legacy of confusion, with some providers continuing to deny care to IFHP clients due to incorrect assumptions about coverage, while others pointed to the administrative processes required by Medavie Blue Cross, the insurer contracted to administer the IFHP, which were perceived by some providers as highly burdensome and difficult to navigate (Chen, 2021).

Based on Rawls' theory of justice, this would be considered a greatly unjust practice. Refugees are essentially excluded from access to health care based on an arbitrary factor, such as time of entry or asylum application date. As mentioned previously, exclusionary measures or feelings of otherness escalate the incidence of mental health issues, as well as amplify the level of vulnerability within refugee groups.

A secondary concern involves the effect exclusionary policy has on Canada's overall population health. Primarily, refugee claimants who are denied health care under the IFHP may eventually become full-fledged Canadian residents. This means the health status of claimants is an essential element of population health. Moreover, once refugees become Canadian citizens, they are immediately eligible for publicly funded Medicare and the appropriate provincial health care scheme based on geographic location. Thus, it becomes increasingly important to focus on prevention strategies, rather than enacting policies that further limit access to public goods.

According to Gostin and Powers, the government has a responsibility to shoulder basic public health principles. They argue that a ‘failure to act expeditiously and with equal concern for all citizens, including the poor and less powerful, predictably harms the whole community’ (Gostin & Powers, 2006). In simpler terms, by allocating an appropriate portion of health care resources for refugee claimants, it becomes possible to prevent avoidable and serious health concerns that later become a burden on our health care system. Following the 2012 cuts, ‘a child with a potentially contagious rash was turned away from a clinic because her IFH program coverage, although valid, was not accepted by the clinic’ (Barnes, 2013). This scenario demonstrates the worth of prevention strategies: without treating the rash, other members of society were exposed to unnecessary risk, and if these residents contracted the rash and visited a local clinic, more health care resources were spent on an avoidable situation.

3.7.1 Gender is a determinant of health

Gender is a key component in the evaluation of refugee health and health inequities, as women face additional barriers to those experienced as part of the refugee population. Refugee women face unique challenges, including increased risk for mental health problems (e.g. postpartum depression) and an increased burden within the family unit as wives and/or mothers (Shishehgar et al., 2017; Zivot et al., 2020), lack of or limited social support networks (Brown-Bowers et al., 2015), reduced employment and educational opportunities (Senthanar et al., 2020), increased difficulty navigating health and social services (Tastsoglou et al., 2014), increased risk for gender-based sexual violence and exploitation (Government of Canada, 2020), reduced language fluency and literacy compared to their male counterparts (Floyd & Sakellariou, 2017; Cheung & Phillimore, 2017), and they are more likely to be refused health care based on their status as

migrants (Hawkins et al., 2021). Of note, difficulty navigating, or the denial of, health care services can lead to delayed care, which is regularly associated with worse health outcomes and increased costs to the health care system (Kraft et al., 2009; Chen et al., 2011). For Canada's immigrant admission categories, refugee women have been found to be less likely to participate in training, not only compared to their male counterparts, but also compared to women in all other admission categories; furthermore, women with children were the least likely to be employed within every admission category (Government of Canada, 2020). Thus, their health and well-being require special attention.

3.8 Conclusion – Summary of Impacts: IFHP Reforms

This section explores how federal policy produces health disparities in association with perceptions of policy rhetoric, legal ramifications, and media portrayals.

The 2012 cuts to refugee health care caused a public uproar in Canadian society, with health care workers being particularly vocal, demonstrating their disapproval of the IFHP changes through media presence and formal legal challenges (Eggertson, 2013). Health care workers joined forces with lawyers, physicians, medical students, pharmacists, members of the Presbyterian Church, the Toronto Board of Rabbis, the Canadian Council for Refugees, and many more to dispute the policy changes through organized protests (Eggertson, 2013; Stall, 2012). Other critics of the 2012 IFHP reforms include professional associations (nurses, social workers, physicians, etc.) as well as the former Ontario Health Minister Deb Matthews (The Canadian Press, 2012b). The cuts were seen as inhumane, unjust, and discriminatory, as they undermined the Canadian values of multiculturalism and the basic human right to health. Many

also questioned the reasoning or motive behind limiting refugee health, a programme that adds minimal burden to Canadian taxpayers (Harris & Zuberi, 2015).

The cuts also had numerous legal ramifications relating to the provision of basic human rights and the right to health care. On July 4th, 2014, the Federal Court of Canada ruled in favour of a legal challenge initiated by two refugee applicants directly impacted by the cuts. The court advised that the 2012 reforms violated existing charter rights, describing the changes as both ‘cruel’ and ‘unjust’ (Chan et al., 2014). Following this verdict, the Conservative government of the day not only appealed the decision, but also ‘quietly eradicated the program’s legal basis’ (Persaud & Webster, 2015). Despite a federal court ruling that discredited the stated reasons for implementing the cuts (i.e. cost savings to taxpayers), the federal government instead chose to replace a 1957 Order in Council to eliminate any legal obligations to supply refugee health care.

3.8.1 COVID-19 and public health risks

This chapter has focused on refugee and migrant health impacts relating to policy changes that occurred prior to the COVID-19 pandemic. Of note, due to limitations on migration-based data related to COVID-19, it is difficult to ascertain the true impact of the COVID-19 pandemic on Canada’s refugee population. According to a variety of media outlets, newcomers, immigrants, and migrant workers have higher COVID-19 risks due to overcrowded housing and employment in jobs that cannot be done remotely (CBC News, 2021; Perkel, 2021; Neustaeter, 2021).

COVID-19 further exacerbated already challenging conditions faced by refugees in Canada, with likely problems including reduced access to adequate accommodations (shelter, water, basic sanitation) and the ability to quarantine; difficulty navigating directives from multiple levels of government (municipal, provincial, federal), protocols, and public health and safety materials;

and increased mental health conditions (anxiety, depression) among newcomers as a result of the fear and uncertainties surrounding the COVID-19 pandemic (Júnior et al., 2020). Other studies found refugees face increased isolation, mental health worries, communication barriers, and economic hardships, in part due to significantly reduced access to services for newcomers as a result of state-imposed lockdowns (Clarke et al., 2021; Brickhill-Atkinson & Hauck, 2021).

These preliminary findings have implications for the health of the Canadian public. Specifically, the difficulty in navigating public health directives coupled with reduced access to health care services means newcomers may not seek timely care, which leads to the spread of infection as well as poor health outcomes. Other research has found inequitable delivery of COVID-19 vaccines to migrants and racialized or visible minority groups, due to inadequate government engagement, lack of targeted information, and vaccination reluctance (Al-Oraibi et al., 2021). To maintain the health of Canadians, migrants must be included in local and national immunisation plans to decrease morbidity and death and to restrict transmission of the virus. Overall, these findings point to existing policy gaps that lead to health inequities for refugees in Canada.

3.8.2 Policy Recommendations

Although 2016 saw a reinstatement of IFHP benefits under the Liberal government, more should be done to ensure that refugees retain equitable access to health care services. In particular, the following recommendations are proposed:

- (1) introduce provisions which ensure that the 2016 IFHP reinstatement of benefits is retroactive and applicable to all refugees;

- (2) introduce a clause which requires language assistance for refugees who have difficulty navigating the health care system; and
- (3) allocate resources for the education of health care staff on the applicability, eligibility, and service delivery of the IFHP.

Finally, general recommendations for federal policy are provided. As observed, policy reforms greatly affect the health of a population. As such, changes to policy require, at minimum, a small-scale review aimed at evaluating the potential for negative health effects prior to implementation. Recommendations include the following:

- (1) providing heightened access to educational programmes targeted at refugees with respect to navigating life in Canada for the purpose of improving social integration;
- (2) introducing refugee-specific policies aimed at reducing unique barriers to health care access;
- (3) reviewing (and making the appropriate changes to) any federal policies that are deemed discriminatory and/or increase the health care burden unnecessarily;
- (4) ensure that all migrant categories cannot be excluded from public health care services in the event of an infectious disease outbreak, pandemic, or epidemic (e.g. COVID-19);
- (5) emphasizing social justice and preventative measures when considering general policy reforms; and,
- (6) utilizing targeted policies and services to support refugees with social integration (paying specific attention to women).

Findings indicate federal policies of Canada have contributed to refugee health disparities. Using an analytical framework based on Rawls' theory of justice, market orientation, and migration studies, we found that Canada's refugees face increased security measures when accessing health

care services; they are also unfairly targeted by federal policy limiting equality of outcome, and they are compelled to provide invasive private data as a requirement for asylum applications.

Canada's refugee system and refugee health care policies have direct ramifications for overall health care quality. When refugees feel a sense of *otherness*, they are more likely to exhibit mental health conditions, and when refugees are denied basic access to health care services, they are more likely to utilize hospital ERs as an alternative (Barnes, 2013). Most importantly, refugees' health status can greatly affect national population health. Further research should explore how other federal, provincial, or municipal policies affect refugee health. New research should also comprehensively investigate the differences in observable health outcomes following the implementation of the 2016 IFHP modifications.

3.8.3 Limitations

The evaluation of the IFHP in this chapter has a deliberately limited scope and does not examine several adjacent debates that shape policy discussions about financing refugee health care. This study did not discuss objections to funding refugee health, such as the free-rider problem (e.g. those without the means to pay should not be provided with services), the magnet problem (providing services to refugees could attract more refugees), and health system concerns related to increased costs (Gray & Ginneken, 2012). In addition, the review does not situate IFHP reform within the current Canadian context of constrained health care capacity and affordability pressures. Finally, this study does not incorporate the wider affordability crisis affecting households, which is relevant to the political and fiscal context in which refugees' health coverage is debated. Given these omissions, the review assumes a social justice stance grounded in Canada's tradition of publicly funded Medicare, while recognizing that a fuller assessment of

feasibility would also need to engage these broader capacity and affordability conditions and compare policy approaches across jurisdictions.

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Chapter 4: Health Disparity Among Health Care Workers (HCWs) in Canada: Evidence from the 2022 Survey on Pandemic Experiences

4.1 Introduction

The COVID-19 pandemic placed a unique strain on health care systems in many countries, which exacerbated existing inequities within health care settings. In Canada, health care workers (HCWs) shouldered the brunt of the crisis, managing overwhelming patient loads, navigating rapidly evolving protocols, and confronting significant personal risk (Canadian Institute for Health Information, 2024). As a result, HCWs have experienced elevated levels of stress, burnout, and emotional exhaustion and physical health problems (Qureshi et al., 2022; Shaukat et al., 2020). These impacts are not uniformly distributed across the workforce, as they are often shaped by existing structural and social inequalities, particularly in relation to socioeconomic factors including ethnicity, income, age, gender, and occupational roles (Gupta and Aitken, 2022; Godefroy et al., 2022). Increasing evidence suggests that the pandemic has disproportionately affected health care workers from visible minority and immigrant backgrounds, both in terms of infection rates and health outcomes (Yong & Germain, 2022; Khunti et al., 2021; Khunti et al., 2023; Abba-Aji et al., 2022).

Studies have shown racialized or visible minority and immigrant health care workers in Canada are more likely to be employed in lower-status, higher-risk positions such as personal support workers (PSWs), long-term care aides, and/or cleaning and maintenance staff in hospitals, roles that have had among the highest exposure to COVID-19 and the fewest protections (Talbot et al., 2026; Sritharan et al., 2025; Darwish et al., 2022; Turcotte & Savage, 2020). International data support these disparities as well. In the United Kingdom, the Office for

National Statistics reported higher COVID-19 mortality rates among racialized or visible minority groups compared to white populations (Ayoubkhani et al., 2020). These disparities are not confined to the general public. Racialized or visible minority health care workers have also reported disproportionately high rates of infection, hospitalization, and psychological distress during the pandemic (Martin et al., 2022).

Similar patterns have been observed in Canada, where immigrants and racialized or visible minority individuals have been overrepresented in COVID-19 case numbers and hospital admissions, both as patients and as workers in high-risk frontline roles (Qureshi et al., 2022). Despite broad recognition of the pandemic's toll on health care workers (HCWs), there remains a notable gap in the Canadian literature examining how health outcomes vary within the HCW workforce by ethnicity and immigration status. Much of the prior research has treated HCWs as a homogeneous group, with limited attention paid to how social location shapes both exposure to COVID-19 and vulnerability to its health and labour-market consequences. These gaps are important given that Canada's health care system depends on immigrant and racialized or visible minority HCWs, who constitute a substantial share of the frontline workforce (Turcotte & Savage, 2020).

This study aims to advance emerging research on health equity during COVID-19 by analyzing perceived general health among Canadian HCWs, with a specific focus on differences by visible minority and immigration status. Drawing on national survey data collected during the pandemic, this chapter employs the social determinants of health (SDoH) to assess why some people in the health care workforce are less healthy than others.

4.2 Literature Review

4.2.1 The Social Determinants of Health

The social determinants of health (SDoH) refer to the conditions in which people are born, grow, live, work, and age, together with the wider structural forces that shape how those conditions are distributed across a population (World Health Organization, 2008). Rather than locating the origins of ill health primarily in individual biology or behaviour, the SDoH perspective directs attention to the social, economic, and political arrangements that pattern health outcomes, what Braveman and Gottlieb (2014) term the causes of the causes of disease. In the Canadian context, Mikkonen and Raphael (2010) identify income, employment and working conditions, education, and race among the central determinants of population health, arguing that these conditions account for a substantial share of the health differences observed among different social groups. This framing has become foundational to contemporary public health and social sciences scholarship, and it underpins the analytic approach of this dissertation.

A key contribution of the SDoH perspective is its distinction between structural and intermediary determinants. In Solar and Irwin's (2010) conceptual framework, social determinants, including socioeconomic and political context and each individual's position within the hierarchies of income, education, occupation, gender, and race, which generate and reinforce systematic differences in the intermediary conditions, such as material circumstances, working environments, and access to health care, through which health is ultimately produced. Health inequities are therefore understood not as isolated or incidental disparities but as the predictable outcome of how social advantage and disadvantage are organized and reproduced. This structural reading is directly relevant to this chapter, which treats immigrant and visible

minority status not as fixed personal attributes but as markers of social position that locate individuals differently within these hierarchies.

The significance of the social determinants as drivers of health is well established in recent Canadian evidence. Analyses of national survey data show that racialized or visible minority and immigrant Canadians frequently report poorer general health than their white, Canadian-born counterparts, and that these gaps persist after adjustment for age and other demographic factors (Lacey et al., 2021). In a study of first- and second-generation Black Canadians, Boamah et al. (2025) found that difficulty accessing health care and unmet basic needs were among the strongest correlates of poor self-rated health, illustrating how material and structural conditions shape even subjective assessments of well-being. Evidence from the care sector reinforces this pattern: Lee et al. (2024) report that income, education, immigration history, and social support are each associated with differences in home care use in Canada, indicating that access to care is itself stratified along the same social lines. Comparable gradients have been documented internationally, including in the United States and the United Kingdom, where socioeconomic position and racialized or visible minority status remain robust predictors of morbidity and mortality (Braveman & Gottlieb, 2014; Marmot & Allen, 2020).

These findings carry particular importance for the study of health care workers' health disparities in Canada. Although health professionals are often assumed to be relatively advantaged by virtue of their employment and health literacy, they remain embedded in the same social structures that produce inequities in the wider population. Occupational conditions, credential recognition, exposure to discrimination, and the intersection of immigrant and racialized or visible minority status can position segments of the health care workforce unequally

with respect to the intermediary determinants of health, a possibility that motivates the analysis that follows. Perceived general health, the outcome examined in this chapter, is widely used in this perspective because it reliably predicts morbidity, functional decline, and mortality, and because it captures the cumulative embodiment of social conditions in a single, comparable measure (Boamah et al., 2025; Lacey et al., 2021). Situating the analysis within the SDoH framework, thus, provides both a theoretical rationale for expecting health disparities among health care workers and an empirical basis for interpreting them as manifestations of structural, and not merely individual, processes.

4.2.2 Diversity Among Canada's Health Care Workers

Canada's health care workforce includes a substantial share of immigrant and racialized or visible minority workers, with concentrations that vary markedly by occupation. Immigration, Refugees and Citizenship Canada reports that immigrants comprise about one quarter of the health care sector overall, including approximately 37% of physicians, 25% of registered nurses, and 42% of nurse aides and related occupations (Immigration, Refugees and Citizenship Canada, 2025). Statistics Canada shows that immigrant and visible minority member's representation is especially pronounced in support roles. In 2016, immigrants comprised 36% of nurse aides, orderlies and patient service associates, and 34% of workers in these occupations belonged to a population group designated as a visible minority, including 12% Black and 11% Filipino workers (Turcotte & Savage, 2020).

Additionally, Statistics Canada's occupational breakdown for nursing and health care support occupations indicates that, in 2016, adult immigrants accounted for roughly 16% of registered nurses and registered psychiatric nurses, 21% of licensed practical nurses, and 30% of nurse aides, orderlies and patient service associates (Cornelissen, 2021). More recent Census-

linked reporting indicates that 31% of people working in health occupations in May 2021 were members of a racialized population, compared with 27% of employed people overall, and that Chinese, Arab, or South Asian Canadians held 25% of general practitioner and family physician positions in May 2021 (Statistics Canada, 2022a). In the same period, Black people accounted for 16% of nurse aides, orderlies and patient service associates, and Filipino people accounted for 15% in those occupations (Statistics Canada, 2022a). Overall, these data underscore the high degree of diversity within Canada's health workforce, particularly in frontline support occupations where immigrant and racialized or visible minority workers are heavily represented.

4.2.3 Perceived Health and Self-Rated Health as Measures of Health Outcomes

Self-rated health (SRH) and perceived health (PH) have become a cornerstone outcome in population and occupational health research. Conceptually, SRH captures an individual's comprehensive appraisal of overall health that integrates diagnosed conditions, symptoms, functional limitations, psychological factors, and social context. In Canada, SRH is a headline quality-of-life indicator and forms part of routine surveillance, underscoring its policy relevance and interpretability for decision-makers (Canadian Institute for Health Information, 2022; Statistics Canada, 2025). The Canadian Institute for Health Information (CIHI) defines perceived health as a global assessment that "predicts other indicators such as mortality" and complements clinical measures, signalling institutional endorsement of SRH as a robust proxy for overall health (2022). Statistics Canada treats perceived health as a headline measure and tracks its distribution over time, enabling benchmarking and subgroup comparisons (Statistics Canada, 2025). Together, these measures of health help to facilitate comparability across datasets and periods, including pandemic and post-pandemic timeframes. Empirically, SRH and PH demonstrate consistent associations with prospective morbidity, health care utilization, and

mortality, even after accounting for objective indicators and clinical risk factors (Cho et al., 2022; Reinwarth et al., 2024).

Two key features make SRH and PH especially valuable for studying health care workers (HCWs). First, these measures are sensitive to cumulative burden from both physical and psychosocial stressors, which are relevant properties in high-strain occupations where mental health, fatigue, and musculoskeletal symptoms are prevalent. Second, these measures are easily facilitated as a repeated measurement in surveys with complex designs. For joint-status analyses, such as observing differences by immigration and visible minority status, the strengths of PH and SRH lie in their responsiveness to social determinants (e.g., income, work conditions, discrimination) that may not be fully captured by clinical records alone. This allows investigators to detect inequities embedded in occupational hierarchies. As SRH and PH are collected in large, representative surveys with design variables (strata, weights, primary sampling units), these measures can be modelled with survey-weighted methods to yield generalizable estimates for policy planning. The literature supports SRH as a theoretically coherent and empirically validated outcome suited to studying workforce health disparities that can be used to illuminate inequities within HCWs (Canadian Institute for Health Information, 2022; Cho et al., 2022; Hamplová et al., 2022; Statistics Canada, 2025).

4.2.4 Occupations and Health Outcomes

Occupational roles and settings are central determinants of worker health through physical demands, psychosocial stress, schedules, and exposure risks, among other factors. Health care workers such as nurses consistently exhibit high levels of burnout, driven by staffing pressures, heavy workloads, and emotionally intense care during COVID-19 (Galanis et al., 2021). Burnout

is also typically linked to absenteeism, intention to leave, and adverse patient outcomes, signalling system-level implications that extend beyond individual well-being (Galanis et al., 2021). Canadian data show that hospital injuries rose in parallel with staffing challenges (i.e., overtime, sick time, reliance on agency staff) through pandemic years, contextualizing the strain faced by inpatient teams (Canadian Institute for Health Information, 2023).

Physical demands remain a longstanding risk, especially for professions with frequent patient handling. Systematic reviews report very high prevalence of work-related musculoskeletal disorders among nurses at over 70% annually, with the lower back, neck, and shoulders most affected (Sun et al., 2023). Interventions such as safe-patient-handling programs, ergonomic training, and equipment access demonstrate benefit but require organizational commitment to implementation and monitoring (Sousa et al., 2023). In community-based and long-term care roles, PSWs experience layered stressors: time pressures, lone working, travel between clients, and emotional labour, all of which can elevate fatigue and psychological strain (Bambra, 2011; Benach et al., 2014). Qualitative research from Canadian home care during COVID-19 also documented heightened fear of infection, shifting protocols, and increased responsibility without adequate support, amplifying job stress (Nizzer et al., 2023).

These patterns underscore a gradient of risk across occupations and settings, with direct-care roles closer to patients and with fewer resources facing greater cumulative burden. Importantly, occupational risk may be compounded by social location. Particularly, as racialized or visible minority and immigrant HCWs are disproportionately represented in support and continuing-care roles, occupation can become a channel through which social inequities translate into differences in health status (Nizzer et al., 2023; Zeytinoglu et al., 2017). For analyses using

perceived general health, occupational covariates (role and setting) aid in clarifying whether disparities reflect social position alone or the structure of work itself (Turcotte & Savage, 2020). The literature thus points to a coherent framework where psychosocial demand and physical load (especially for nursing and PSW roles) elevate risk of burnout, systemic staffing strain compounds that risk, and organizational interventions (ergonomics, adequate staffing) are necessary to mitigate harm (Canadian Institute for Health Information, 2023; Galanis et al., 2021; Sun et al., 2023; Sousa et al., 2023; Nizzer et al., 2023).

4.2.5 Impact of Visible Minority Status on Health Outcomes

It has been widely reported internationally that racialization and immigrant status are associated with unequal exposures that impact and shape health outcomes. In Canadian settings, racialized or visible minority populations report barriers to care, experiences of discrimination, and worse outcomes on several indicators relative to non-racialized groups, even after adjusting for socioeconomic factors (Mahabir et al., 2021; Syed, 2020). During the COVID-19 period, these disparities intensified as racialized or visible minority groups experienced higher infection and mortality rates, reflecting differential exposure in essential or frontline roles, crowded housing, and structural barriers to prevention and care (Bushnik et al., 2022; Vang & Ng, 2023).

Mechanisms linking minority status to poorer health outcomes include discrimination-related stress and reduced access to protective resources. Qualitative accounts from Canadian health systems document “everyday racism” and institutional barriers shaping patient and worker experiences, highlighting how discrimination in care environments exacerbates health inequities (Mahabir et al., 2021). Within the workforce specifically, racialization combines with immigration to influence job assignment, promotion, and security, all of which are features of

employment that are downstream determinants of health through income and psychosocial demand (Syed, 2020). During the pandemic, Statistics Canada reported that people who identified as visible minorities were 1.7 times more likely to have been infected than non-visible minority counterparts, net of other characteristics, which is consistent with differential exposure risks in essential sectors (Bushnik et al., 2022). Others also report erosion of the healthy-immigrant advantage under stressors related to work and discrimination, especially among racialized or visible minority immigrants (Vang & Ng, 2023).

These findings are important for HCWs because immigrant and racialized or visible minority workers constitute a substantial share of frontline roles, including in long-term care and support occupations where physical demands and emotional labour are high. Evidence illustrating spatial and occupational concentration of risk within Canadian metropolitan regions further underscores how minority status and job structure co-produce health vulnerability (Adhikari et al., 2024). Social determinants of health (SDoH) perspectives suggest that the combination of immigration and racialization can compound exposures, through discriminatory policies and constrained advancement, beyond what either dimension alone would predict.

4.2.6 COVID-19 Impacts on Visible Minority Health Care Workers

The COVID-19 pandemic disproportionately affected minority ethnic and immigrant HCWs through both infection risk and broader psychosocial impacts. In the UK-REACH cohort of more than 10,000 HCWs, ethnic minority (the United Kingdom term for racialized or visible minority) status was independently associated with higher odds of SARS-CoV-2 infection after adjustment for demographic and occupational factors, implicating differential exposure and workplace processes (Martin et al., 2022). Complementary qualitative work from UK-REACH reported that

HCWs from diverse ethnicities perceived greater risk and described shortcomings in risk management and support, adding insight into how organizational practices translated into unequal burdens that may have an impact on health (Qureshi et al., 2022).

Canadian data also support the narrative of unequal health outcomes among minority HCWs. A Public Health Agency of Canada's report documented higher COVID-19 mortality in socioeconomically disadvantaged areas and highlighted equity-relevant gradients during the first pandemic year (2022). Statistics Canada data also further showed that people identifying as visible minorities were significantly more likely to report prior infection than non-visible minority peers, net of age and other covariates, underscoring differential exposure in essential workforces (Bushnik et al., 2022). Additionally, research in the Greater Toronto Area linked neighbourhood visible minority concentration and occupation to infection patterns, illustrating how spatialized social structure and job composition produced localized risk (Adhikari et al., 2024).

These disparities intersect with occupational hierarchies in health care systems. Research indicates that racialized or visible minority and immigrant health care workers are disproportionately concentrated in direct care and support roles and that these positions are often characterized by more precarious employment conditions and fewer protections. Canadian and Ontario analyses show that immigrants constitute a substantial share of nursing and health care support occupations, including support worker categories that deliver intensive hands-on care (Harun & Walton-Roberts, 2022). In the Greater Toronto Area, personal support workers, a high-contact direct care workforce, are described as mainly racialized or visible minority and

immigrant women, who are documented as having low income, lack of schedule control and access to benefits and protections (Pinto et al., 2022).

During COVID-19, Ontario long-term care and retirement home staff also showed patterned infection risk by sociodemographic characteristics, and access to paid sick leave was associated with lower SARS-CoV-2 seropositivity, supporting the mechanism that unequal protections can translate into differential exposure (Fahim et al., 2025). Other Canadian evidence shows elevated distress, perceived lack of safety, and dissatisfaction with risk assessments among minority ethnic HCWs, pointing to organizational determinants (e.g., PPE access, redeployment patterns, communication) that compounded risk during surges (Martin et al., 2022; Qureshi et al., 2022). For perceived general health outcomes, these pathways imply that the joint influence of immigration and racialization is also grounded in workplace practices and structural arrangements that concentrate risk.

4.3 Research Question(s) and Hypothesis

The objective of this study is to examine differences in perceived health (PH) among health care workers during the COVID-19 pandemic. The inquiry centres visible minority status and immigrant status as key axes of stratification and considers their combined associations with perceived health during the pandemic, which was a period of unprecedented system strain for health care workers. The study is guided by the following questions:

- (1) How did the COVID-19 pandemic affect the perceived health of health care professionals in Canada?
- (2) What role, if any, did visible minority status and immigrant status, both independently and in combination, play in shaping any observed differences in perceived health?

My hypothesis is that health care workers who are members of visible minority groups and/or immigrants will report lower perceived health during the COVID-19 pandemic than non-visible minority and non-immigrant health care workers. Further, the lowest perceived health is expected among those who are both a visible minority and an immigrant, consistent with the expectation that overlapping social positions may compound exposure to workplace risks and psychosocial stressors during periods of heightened system strain.

4.4 Data and Methods

4.4.1 Data Source

This study uses data from the Survey on Health Care Workers' Experiences During the Pandemic (SHCWEP), a nationally representative cross-sectional survey conducted by Statistics Canada in 2021. The survey looks at the experiences of health care workers (HCWs) across Canada during the COVID-19 pandemic, including general health, working conditions, and job impacts. The study sample includes health care workers aged 18 years and older who provided health care services with valid responses on the key variables of interest. Sampling weights (WTS_P) were applied to account for the survey design.

4.4.2 Outcome Variable

In this study, the key outcome variable of interest is perceived general health. This variable is coded dichotomously. A *yes* value indicates a survey response of either good, very good, or excellent perceived general health, whereas a *no* value indicates a survey response of either poor or fair. The practice of coding self rated or perceived health from a five category Likert scale into a binary outcome (for example, fair or poor versus good, very good, or excellent) is widely used in epidemiology and the social sciences as it supports clearer interpretation and communication

of results, including in policy oriented analyses (Manor et al., 2000; Salomon et al., 2009).

Researchers also adopt this approach when responses are skewed or when some categories have small cell counts, since sparse data can yield unstable estimates and collapsing categories can mitigate sparsity-related instability in regression models (Greenland et al., 2016).

4.4.3 Focal Variables

The focal independent variables in this analysis are immigrant status and visible minority status. The immigrant status variable distinguishes between non-immigrants, immigrants or non-permanent residents (moving forward, this category will only be referred to as ‘immigrant’), and those who did not state their immigrant status. The visible minority variable classifies respondents as either visible minority, not visible minority, and those that did not state their visible minority status. Statistics Canada defines visible minority in accordance with the Employment Equity Act as “persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour” (Statistics Canada, 2022b).

Additionally, a composite variable was constructed comprising nine categories: (1) non-immigrant, not visible minority; (2) non-immigrant, visible minority; (3) immigrant, not visible minority; (4) immigrant, visible minority; (5) non-immigrant, visible minority status not stated; (6) immigrant, visible minority status not stated; (7) immigrant status not stated, not visible minority; (8) immigrant status not stated, visible minority; and (9) immigrant and visible minority status not stated.

4.4.4 Control Variables

Confounding variables were identified based on factors shown in prior research to influence both health outcomes and occupational status, including demographic, occupational,

and individual health factors. Existing studies have consistently demonstrated that variables such as age, gender, income, and occupation are strongly associated with perceived health and must therefore be controlled (Bonner et al., 2017; Cheung & Mui, 2022; Cott et al., 1999; Shields & Shooshtari, 2001). Meanwhile, mental health has been shown to be closely correlated with general self-rated health, serving as a meaningful confounder (Li & Nowrouzi-Kia, 2024). Thus, the control variables of this study are: age, gender, household income, occupational group, province/region, and perceived mental health.

- Demographic variables: age (18–34, 35–44, 45–54, 55 years or older), gender (male or female), and household income (under \$100,000, \$100,000 to \$149,999, \$150,000 or more, and those that did not state their household income).
- Occupational factor: group of National Occupational Classification (physicians, nurses, personal support workers or care aides, and other health occupations).
- Geographic factor: province or region (Atlantic provinces, Quebec, Ontario, Manitoba, Saskatchewan, Alberta, British Columbia).
- Perceived mental health or PMH (excellent, very good, good, fair, poor).

Perceived mental health was retained because omitting an established correlate of self-rated health would risk omitted-variable bias. General and mental self-rated health are empirically distinguishable – related but not interchangeable – dimensions of self-assessed well-being. In one large population cohort, self-reported general health and self-reported mental health each retained independent associations with clinical outcomes after adjusting for the other, indicating that neither measure is simply redundant with the other (Ul-Haq et al., 2014). This is consistent with the approach taken in other research on perceived/self-rated health among health care and

other occupational populations, which likewise controls for mental health status when modelling general self-rated health (Li & Nowrouzi-Kia, 2024). At the same time, perceived mental health is conceptually proximate to perceived health, and raises the possibility of model overadjustment, as PMH may partly capture the same underlying construct as the outcome PH. This is a recognized risk in social epidemiology specifically, since adjusting for a variable that lies on the causal pathway between a structural exposure (such as immigrant or visible minority status) and a health outcome can bias estimates toward the null rather than removing confounding (Schisterman et al., 2009; van Zwieten et al., 2022). However, as the direction of the relationship between social position, mental health, and perceived general health cannot be fully adjudicated with cross-sectional data, this possibility is examined as a limitation in sections 4.6.5 and 4.8.2.

4.4.5 Statistical Analysis

The study analysis used design-based binomial logistic regression (Stata 19) to estimate the odds of good perceived general health. Multicollinearity did not pose a significant concern (maximum variance inflation factor < 5). Model fit was evaluated using the survey-adjusted Hosmer–Lemeshow goodness-of-fit test and found to be satisfactory (Archer et al., 2007). As this study uses de-identified secondary data, ethical clearance is not required.

4.4.6 Descriptive Statistics

The majority of the respondents of this study sample (89.9%) rated their perceived health as good, very good, or excellent, while only 10.1% reported poor or fair health. This indicates generally positive self-assessed health among health care workers in the sample. **Table 4** shows the distribution and characteristics of the sample.

With respect to visible minority status, most respondents (76.6%) do not belong to a visible minority group, while 16.9% identified as a visible minority and 6.5% did not state their visible minority status. Similarly, the majority (75.9%) were non-immigrants, with only 18.1% being immigrants or non-permanent residents, and 6% did not state their immigrant status. When immigrant and visible minority status were combined as a composite variable, the largest subgroups were non-immigrant, not visible minorities (71%), followed by immigrant visible minorities (13.4%). The remaining categories represented a far smaller proportion of the study sample, at roughly 3% for each group.

The sample displayed a relatively balanced age distribution, with 21.4% aged 18 to 34 years, 25.1% aged 35 to 44, 24% aged 45 to 54, and 29.5% aged 55 years or older. In terms of gender, women made up a significant majority (77%) compared to men (23%), which reflects the gendered nature of the health care workforce. Regarding household income, 31.1% of respondents reported annual earnings under \$100,000, 16.8% between \$100,000 and \$149,999, and 33.8% \$150,000 or more, and 18.3% did not state their household income level.

In terms of National Occupational Classification (NOC) groups, nurses (28.3%) represented the largest occupational group, followed by other health care workers (28%), personal support workers or care aides (23.9%), and physicians (19.8%). Lastly, regional representation was broad with the Atlantic provinces accounting for the largest share (29.1%), followed by Quebec (12.3%), British Columbia (12.6%), Alberta (11.9%), Ontario (11.7%), Manitoba (11.6%), and Saskatchewan (10.6%).

Table 4: Respondents' Characteristics

N = 11,994	Count (%)
Perceived health	
Good/Very Good/Excellent	10,781 (89.9%)
Poor/Fair	1,213 (10.1%)
Visible minority status	
Not a visible minority	9,189 (76.6%)
Visible minority	2,030 (16.9%)
Not stated	775 (6.5%)
Immigrant status	
Non-immigrant	9,102 (75.9%)
Immigrant or non-permanent resident	2,168 (18.1%)
Not Stated	724 (6.0%)
Immigrant and visible minority status	
Non-immigrant, not visible minority	8,521 (71.0%)
Non-immigrant, visible minority	304 (2.5%)
Immigrant, not visible minority	373 (3.1%)
Immigrant, visible minority	1,606 (13.4%)
Non-Immigrant, visible minority status not stated	277 (2.3%)
Immigrant, visible minority status not stated	189 (1.6%)
Immigrant status not stated, not visible minority	295 (2.5%)
Immigrant status not stated, visible minority	120 (1.0%)
Immigrant and visible minority status not stated	309 (2.6%)
Age group	
18 to 34 years	2,556 (21.4%)
35 to 44 years	3,003 (25.1%)
45 to 54 years	2,874 (24.0%)
55 years and older	3,523 (29.5%)
Gender	
Male	2,751 (23.0%)
Female	9,207 (77.0%)
Total household income	
Under \$100,000	3,736 (31.1%)
\$100,000 to \$149,999	2,013 (16.8%)
\$150,000 or more	4,053 (33.8%)
Not stated	2,192 (18.3%)
National occupation classification (NOC)	
Physician	2,375 (19.8%)
Nurse	3,393 (28.3%)
PSW/care aides	2,866 (23.9%)
Other	3,360 (28.0%)

Province or region	
Atlantic provinces	3,496 (29.1%)
Quebec	1,481 (12.3%)
Ontario	1,408 (11.7%)
Manitoba	1,396 (11.6%)
Saskatchewan	1,271 (10.6%)
Alberta	1,433 (11.9%)
British Columbia	1,509 (12.6%)
Perceived mental health	
Excellent	1,355 (11.3%)
Very Good	3,481 (29.1%)
Good	4,492 (37.6%)
Fair	2,134 (17.9%)
Poor	485 (4.1%)

Table 5 presents the weighted distribution of health care workers across four occupational groups (N = 11,994). Clear occupational gradients are evident. Immigrants or non-permanent residents constitute a larger share of personal support workers or care aides (29.6%) compared to physicians (22.2%), nurses (14.6%), or the “Other” occupational group (8.8%). A similar pattern is observed for visible minority status: visible minority workers represent 28% of personal support workers or care aides, compared with 18.6% of physicians, 14% of nurses, and 9.3% of workers in the “Other” category. Taken together, these distributions indicate that immigrant and visible minority representation is comparatively concentrated among personal support workers or care aides, whereas the “Other” occupational group has the lowest representation on both measures.

Table 5: Visible Minority Status and Immigrant Status by Occupation

National occupation classification (NOC) N=11,994				
	Physicians	Nurses	PSW/care aides	Other
Not a visible minority	1,689 (71.1%)	2,751 (81.1%)	1,911 (66.7%)	2,838 (84.5%)
Visible minority	441 (18.6%)	475 (14.0%)	803 (28.0%)	311 (9.3%)
Visible Minority Status Not Stated	245 (10.3%)	167 (4.9%)	152 (5.3%)	211 (6.3%)
Non-immigrant	1,654 (69.6%)	2,731 (80.5%)	1,870 (65.2%)	2,847 (84.7%)
Immigrant or non-permanent resident	527 (22.2%)	495 (14.6%)	849 (29.6%)	297 (8.8%)
Immigrant Status Not Stated	194 (8.2%)	167 (4.9%)	147 (5.1%)	216 (6.4%)

4.5 Results

The results discussed in this section can be found in **Table 6**, which presents logistic regression models predicting the odds of reporting poor or fair perceived health among health care workers in Canada ($n = 11,994$). The full eligible survey sample described in Section 4.4.1 comprises 11,994 respondents; the regression models reported in Table 6 are estimated on the 11,875 respondents (99.0% of the eligible sample) with complete data on all covariates included in the models, after listwise deletion of the small number of cases with missing values on one or more covariates. This complete-case analytic sample is used consistently across Models 1 through 3.

4.5.1 Impacts of Immigrant Status and Visible Minority Status on Perceived Health

Model 1 investigates visible minority status, Model 2 investigates immigrant status, and Model 3 investigates the joint associations of immigrant status and visible minority status using the nine-

category composite variable described in Section 4.4.3 (four categories cross-classifying immigrant and visible minority status where both are stated, plus five additional categories capturing “not stated” responses on one or both measures). All models controlled for demographic, socioeconomic, occupational, regional, and health factors.

In Model 1, visible minority status was significantly associated with poorer perceived health. Visible minority health care workers had 1.61 times higher odds of reporting poor or fair health compared to non-visible minority counterparts (OR = 1.61, $p < 0.001$). In Model 2, immigrant status was found to be significant. Immigrant or non-permanent resident health care workers had 1.56 times higher odds of reporting poor or fair health compared to non-immigrants (OR = 1.56, $p < 0.001$). The similarity in magnitude between the visible minority and immigrant coefficients indicates that both visible minority and migration-related factors contribute to perceived health inequalities for health care workers.

Model 3 integrated the two markers into a composite variable to provide a joint-status analysis of immigrant and visible minority status. This approach compares combined status categories directly but does not constitute a formal statistical interaction test, and its results should be interpreted accordingly. Relative to non-immigrant, not visible minority health care workers, immigrant visible minorities had significantly higher odds of poor or fair perceived health (OR = 1.72, $p < 0.001$). In contrast, no other combinations of immigrant and visible minority status showed statistically significant differences from the reference group. This suggests that the joint status of race/ethnicity and immigrant status, rather than either factor alone, is most strongly associated with perceived health among health care workers.

4.5.2 Other Factors Impacting Perceived Health

Across all models, age was positively associated with poorer self-rated health. Workers aged 45–54 (OR $\approx$ 1.95–2.09, $p < 0.001$) and those aged 55 years and older (OR $\approx$ 1.80–2.02, $p < 0.001$) had higher odds of reporting poor or fair perceived health relative to those aged 18–34 years. This indicates an association between advancing age and diminished perceived health.

Total household income showed a clear, graded relationship with perceived health. Compared to respondents earning under \$100,000, those in the \$100,000–\$149,999 category had about half the odds of poor/fair health (OR $\approx$ 0.58–0.59, $p < 0.01$), while those earning \$150,000 or more had 34% lower odds (OR = 0.66, $p < 0.05$) across all models. These results align with the well-documented socioeconomic gradient in health, even across occupational categories within a professional sector such as health care.

Within occupational groups, occupational differences were observed relative to physicians as the reference. Nurses had significantly higher odds of reporting poor/fair health in all three models (Model 1 OR = 1.83, $p < 0.01$; Model 2 OR = 1.76, $p < 0.01$; Model 3 OR = 1.78, $p < 0.01$). Personal support workers and care aides also demonstrated significantly higher odds of poor/fair health across models (Model 1 OR = 2.11, $p < 0.001$; Model 2 OR = 2.05, $p < 0.001$; Model 3 OR = 2.03, $p < 0.001$), corresponding to roughly 2.03 to 2.11 times the odds relative to physicians. In contrast, the “Other” occupational category was not statistically significant in any model. These results are consistent with existing literature and broader evidence that lower-status health care roles carry higher physical and emotional demands that often translate into poorer health outcomes.

Regional differences were modest but noteworthy. Relative to workers in the Atlantic provinces, those in Ontario (OR $\approx$ 1.33–1.35, $p < 0.05$) had higher odds of poor/fair health, while respondents in Saskatchewan (OR $\approx$ 0.74–0.76, $p < 0.05$) tended to report better perceived health.

Finally, perceived mental health showed a pronounced gradient in the odds of reporting poor/fair perceived health. Those reporting good mental health had about 3.5 times the odds of poor/fair perceived health relative to those with excellent mental health (OR $\approx$ 3.49–3.52, $p < .001$), while those reporting fair and poor mental health had approximately 24 times and 76–78 times the odds, respectively (OR $\approx$ 24.40–24.86 and 76.03–78.05, $p < .001$).

Table 6: Logistic Models Predicting Odds of Poor/Fair Perceived Health

	Model 1 n=11,875	Model 2 n=11,875	Model 3 n=11,875
Visible minority status			
Not a visible minority (ref.)	—	—	—
Visible minority	1.61***	—	—
Not stated	1.77	—	—
Immigrant status			
Non-immigrant (ref.)	—	—	—
Immigrant or non-permanent resident	—	1.56***	—
Not Stated	—	1.19	—
Immigrant and visible minority status			
Non-immigrant, not visible minority (ref.)	—	—	—
Non-immigrant, visible minority	—	—	1.25
Immigrant, not visible minority	—	—	0.95
Immigrant, visible minority	—	—	1.72***
Non-Immigrant, visible minority status not stated	—	—	1.18
Immigrant, visible minority status not stated	—	—	2.26
Immigrant status not stated, not visible minority	—	—	0.56
Immigrant status not stated, visible minority	—	—	1.18
Immigrant and visible minority status not stated	—	—	2.04
Age group			
18 to 34 years (ref.)	—	—	—

35 to 44 years	1.42	1.34	1.38
45 to 54 years	2.09***	1.95***	2.00***
55 years and older	2.02***	1.80***	1.93***
Gender			
Male (ref.)	—	—	—
Female	1.32	1.28	1.29
Total household income			
Under \$100,000 (ref.)	—	—	—
\$100,000 to \$149,999	0.59**	0.58**	0.58**
\$150,000 or more	0.66*	0.66*	0.66*
Not stated	0.85	0.87	0.85
National occupation classification (NOC)			
Physician (ref.)	—	—	—
Nurse	1.83**	1.76**	1.78**
Personal support worker/care aide	2.11***	2.05***	2.03***
Other	1.14	1.10	1.12
Province or region			
Atlantic provinces (ref.)	—	—	—
Quebec	0.95	0.95	0.94
Ontario	1.35*	1.35*	1.33*
Manitoba	0.79	0.79	0.78
Saskatchewan	0.75*	0.76*	0.74*
Alberta	0.76	0.78	0.76
British Columbia	1.10	1.12	1.11
Perceived mental health			
Excellent (ref.)	—	—	—
Very Good	0.84	0.84	0.84
Good	3.51***	3.49***	3.52***
Fair	24.42***	24.40***	24.86***
Poor	76.03***	77.17***	78.05***

*** p<.001, ** p<.01, *p<.05

Note 1: Sampling-weighted standard errors and 95% confidence intervals for all coefficients are reported in Appendix A (Supplementary Statistical Detail for Table 6).

Note 2: The analytic sample for Models 1–3 reflects complete cases only; see Section 4.5 for an explanation of the difference from the full eligible sample.

4.5.3 Model Robustness: C Statistic and Proportional-odds Assumption

Model 3 discriminative ability was evaluated using the c-statistic, area under the ROC curve

(Hosmer et al., 2013), and was found to discriminate well between respondents with and without

poor/fair perceived health (c-statistic = 0.84, 95% CI [0.83, 0.86]). In addition, an ordinal

robustness check using the full five-category self-rated health measure confirmed that the joint immigrant and visible minority disparity was not an artifact of the binary poor/fair cut point. There was no evidence of a violation of the proportional-odds assumption, $\chi^2(69) = 71.58$, $p = .392$, and the same category remained strongly associated with worse health across the full scale: expressed in the same direction as Models 1–3, immigrant visible minority workers had 1.79 times the odds of reporting worse health at any given threshold of the five-category scale (OR = 1.79, 95% CI [1.54, 2.08], $p < .001$; equivalently, OR = 0.56 for the odds of reporting better health, given the poor-to-excellent coding of the ordinal outcome).

4.5.4 Interaction Effects

To examine whether the associations between visible minority status, immigrant status, and perceived health were concentrated within particular segments of the health care workforce rather than operating uniformly across it, two sets of two-way interaction terms were tested (see **Table 7**). The first set tested whether the visible minority/immigration penalty varies by occupation, and the second tested whether it varies by gender. Each focal variable, visible minority status, immigrant status, and the joint immigrant/visible minority composite was interacted with occupation and with gender. For each specification, the joint contribution of the interaction terms was evaluated using a design-based (survey-adjusted) Wald test, following recommended practice for assessing interaction effects in nonlinear models (Mize, 2019).

None of the three occupation-based interaction tests reached statistical significance (see **Table 7, Panel A**). The association between visible minority status and perceived health did not differ significantly across occupational groups, $F(6, 11869) = 0.52$, $p = .797$, nor did the association between immigrant status and perceived health, $F(6, 11869) = 1.14$, $p = .338$. The corresponding test for the joint immigrant/visible minority composite was also non-significant,

$F(22, 11807) = 0.99, p = .473$; because this 9×4 specification produces several sparse and, in two instances, non-estimable cells, it is reported only as a supplementary check on the primary visible minority and immigrant-status interactions.

The three gender-based interaction tests were similarly non-significant (see **Table 7, Panel B**). The association between visible minority status and perceived health did not differ significantly between men and women, $F(2, 11873) = 0.58, p = .560$, nor did the association between immigrant status and perceived health, $F(2, 11873) = 1.03, p = .358$. A third test of the joint immigrant/visible minority composite by gender was also non-significant, $F(8, 11867) = 1.19, p = .303$.

A supplementary test of whether occupation's own association with perceived health differs by gender, rather than the visible minority and immigration penalty itself, was likewise non-significant (see **Table 7, Panel C**), $F(3, 11872) = 1.35, p = .257$.

Table 7: Wald Tests for Interaction (Effect-Modification) Terms

Interaction term	F (df1, df2)	p	Conclusion
<i>A. Does the visible minority/immigration penalty differ by occupation?</i>			
Visible minority status $\times$ Occupation	0.52 (6, 11869)	.797	No modification
Immigrant status $\times$ Occupation	1.14 (6, 11869)	.338	No modification
Immigrant–visible minority composite $\times$ Occupation ^a	0.99 (22, 11807)	.473	No modification
<i>B. Does the visible minority/immigration penalty differ by gender?</i>			
Visible minority status $\times$ Gender	0.58 (2, 11873)	.560	No modification
Immigrant status $\times$ Gender	1.03 (2, 11873)	.358	No modification
Immigrant–visible minority composite $\times$ Gender	1.19 (8, 11867)	.303	No modification
<i>C. Supplementary check</i>			
Occupation $\times$ Gender ^b	1.35 (3, 11872)	.257	No modification

^a Supplementary; the 9×4 specification yields several sparse and non-estimable cells (e.g., physicians with immigrant status not stated and visible minority; PSWs with non-immigrant, visible minority status not stated), which Stata excludes from estimation, reducing the analytic sample by 46 cases relative to the other models in this table.

^b Tests whether occupation's own association with perceived health differs by gender, rather than whether the visible minority/immigration penalty does.

4.6 Discussion

4.6.1 Combined Immigrant and Visible Minority Status Health Disparities

The respondents with both immigrant and visible minority status tend to report poor or fair perceived health ($OR = 1.72, p < .001$). This pattern indicates that disparities reflect the combined associations of immigration and visible minority status rather than either dimension alone. Immigrant, visible minority health care workers are disproportionately represented in precarious, lower-status, and physically demanding roles (such as personal support and care aides), where workloads intensified during the pandemic (Martin et al., 2022; Qureshi et al., 2022; Syed, 2020). These roles are often characterized by limited job security, irregular scheduling, and constrained access to organizational health supports, conditions that may contribute to chronic stress and less favorable self-assessments of health (Syed, 2020). Moreover, the strength of association for the immigrant-only and visible minority-only models was smaller, reinforcing that the combined exposure is most relevant to understanding the elevated risk for poor/fair perceived health.

Overall, these findings align with the “double disadvantage” hypothesis, whereby minority status and immigrant identity are jointly associated with greater exposure to psychosocial and structural stressors (Denise, 2014; Bowleg, 2012). In this context, immigration and visible minority status may jointly heighten exposure to stressors such as discrimination, credential devaluation, and constrained control over work, thereby increasing the likelihood of

poorer self-rated health among immigrant, visible minority workers (Denise, 2014; Bowleg, 2012). Public health scholarship on compounding social disadvantage further clarifies that these disadvantages are not merely cumulative but structurally intertwined, shaping work organization, supervision, and advancement in ways that can systematically impact health outcomes within the same occupational sector (Bowleg, 2012). Together, these perspectives are consistent with the observed pattern in which the joint categories of immigrant and visible minority show the highest probability of reporting poor/fair health.

4.6.2 Socioeconomic and Occupational Gradients

The observed income gradient reinforces longstanding evidence on the social determinants of health (Solar & Irwin, 2010). Health care workers with household incomes above \$100,000 had significantly lower odds of poor/fair health, suggesting that financial security and access to resources remain powerful protective factors even within a relatively privileged occupational sector. Income disparities also correlate with occupational stratification, as physicians and senior nurses typically occupy higher income tiers, whereas PSWs and care aides often fall below \$100,000. This gradient therefore mirrors both class and occupational hierarchies within the health system.

Occupational differences provide additional context for the observed inequities in poor or fair health. Relative to physicians, both nurses and PSWs or care aides consistently exhibited elevated odds of poor or fair health across model specifications, with the magnitude of association larger for PSWs or care aides (OR approximately 2.03 to 2.11) than for nurses (OR approximately 1.76 to 1.83). The persistence of these differences across models suggests that job role remains a key predictor of self-reported health. This pattern aligns with research

documenting substantial burnout, musculoskeletal strain, and emotional exhaustion among nurses during COVID-19, particularly under conditions of high workload, staffing pressure, and sustained exposure to patient suffering (Dyrbye et al., 2019; Galanis et al., 2021). The evidence is also in line with qualitative findings from Canadian long-term care settings describing intensified emotional labour, fear of infection, and role strain among PSWs, conditions that plausibly contribute to poorer self-rated health (Nizzer et al., 2023). Together, these findings are consistent with a gradient of risk aligned with task intensity, staffing patterns, and proximity to direct care during pandemic surges (Galanis et al., 2021; Nizzer et al., 2023).

These patterns are directly substantiated by this dissertation's own qualitative findings in Chapter 2. PSWs and eldercare staff described chronic understaffing that compressed care routines and extended workloads (Section 2.5.1), and sustained emotional labour compounded by grief, fear, and the absence of institutional recognition (Sections 2.5.3, 2.5.5). Because Chapter 2's respondents describe the same PSW category that this chapter identifies as carrying among the largest odds of poor/fair perceived health, the two chapters offer complementary evidence for the same underlying disparity. Specifically, Chapter 2 documents the occupational conditions that Chapter 4's national survey data show are associated with the poorest self-rated health outcomes for the PSW occupational group.

4.6.3 Regional Variation and Policy Context

Regional differences also emerged, with Ontario health care workers displaying higher odds of poor health than those in the Atlantic provinces. This may be explained by Ontario's larger population, as well as existing health care staffing shortages, all of which may have heightened work-related strain and psychological distress (Styra et al., 2022). In contrast, health care

workers in Saskatchewan reported better perceived health, possibly reflecting differences in provincial policy, health care capacity, or community transmission rates during the study period. These regional variations highlight the importance of contextualizing workforce health within subnational policy environments, and warrants future research to shed light on interprovincial and regional differences.

4.6.4 Age and Cumulative Work Exposure

The strong positive association between age and poor/fair perceived health supports the interpretation that health may decline as we age (Bonner et al., 2017). Alternatively, occupation-specific interpretations suggest that cumulative exposure to occupational strain and physical demands contributes to long-term health deterioration (Yassi & Lockhart, 2013; Denton et al., 2021). For example, older health care workers may experience musculoskeletal disorders, fatigue, and burnout associated with decades of patient care, particularly in physically intensive roles. Additionally, this finding aligns with existing literature indicating that aging health care workers face mounting health risks without adequate systemic supports or ergonomic accommodations (Montayre et al., 2023; Stimpfel et al., 2020; Sousa et al., 2023).

4.6.5 Perceived Mental Health

The strong gradient observed between perceived mental health and the odds of reporting poor/fair perceived health suggests a close interrelationship between mental and physical well-being among health care workers. Compared with those reporting excellent perceived mental health, those reporting very good mental health did not differ significantly in their odds of poor/fair perceived health. However, once respondents rated their mental health as good, fair, or poor, the odds of reporting poor/fair perceived health increased sharply, with particularly large

odds ratios for those in the fair and poor mental health categories. The magnitude of these odds ratios, together with the conceptual overlap between perceived mental health and perceived general health, raises the possibility of overadjustment as previously discussed. Perceived mental health may capture some of the same underlying construct as the outcome, or may act as a mediating pathway linking social position to perceived general health rather than functioning purely as a confounder. Because the focal estimates for immigrant and visible minority status are net of perceived mental health, the reported associations may therefore be conservative if mental health partly mediates, rather than merely confounds, these relationships.

From an occupational health perspective, this association is particularly concerning given the high levels of stress, burnout, and moral distress that have been documented among health care workers, especially in the context of the COVID-19 pandemic (Ferry et al., 2021; Spilg et al., 2022). Overall, these findings align with extensive evidence that mental and physical health are strongly intertwined, and that psychological distress, depressive symptoms, and anxiety are associated with poorer perceived health and increased risk of chronic conditions (Galanis et al., 2021; Zheng et al., 2021).

4.6.6 Interaction Effect Implications

Across all six interaction tests, spanning visible minority status, immigrant status, and their joint composite, each interacted in turn with occupation and with gender, none reached statistical significance. The supplementary test of whether occupation's own association with perceived health varies by gender was likewise non-significant. Taken together, these results indicate that the associations reported in Section 4.5 are not concentrated within particular occupational or gender groups. The more defensible reading is that visible minority status and immigration

operate as pervasive disparities across the health care workforce rather than as associations confined to its most precarious occupational corners. This reinforces the joint-status pattern discussed in Section 4.6.1. Since the health disadvantage associated with visible minority status and immigration cannot be shown to differ significantly across occupational and gender lines, it cannot be explained solely as an artifact of sorting into lower-status roles. The disparity instead appears structural and broad-based, embedded across the workforce, a pattern consistent with the social determinants of health framing adopted throughout this dissertation (e.g., Section 1.2.1). These null results warrant appropriate caution. Non-significant omnibus tests indicate an absence of detectable effect modification rather than positive evidence that the associations are identical across groups, and this study's power to detect moderation within the smaller occupational categories is limited.

Overall, this strengthens the central finding of this chapter that the joint status of immigration and visible minority background has significant negative effects on perceived health among Canada's health care workers. The analysis provides, however, no evidence that this health disparity is concentrated in a particular occupation or gender, and it does not appear to be an artifact of model specification or outcome coding.

4.6.7 Implications for Equity in the Health Care Workforce

Collectively, these findings underscore that systemic inequities exist within the health care system workforce itself, a critical insight given that health care workers are typically conceptualized as agents of care rather than subjects of inequity. The higher prevalence of poor/fair perceived health among immigrant visible minorities suggests that Canada's health care institutions are not immune to the broader social gradients they seek to address among patients.

Such disparities may undermine workforce sustainability and service quality in the short and long term. Chronic stress, fatigue, and perceived poor health among marginalized workers can contribute to higher turnover, absenteeism, and reduced job satisfaction, factors that further exacerbate health care staffing crises (Lee et al., 2023; Dyrbye et al., 2020; Jun et al., 2021). Recognizing and addressing internal inequities in health workforce well-being is therefore both an ethical and operational imperative.

Additionally, the persistence of visible minority and immigrant health disparities despite adjustment for income and occupation may suggest that structural and social mechanisms, such as discrimination, may play a role in observed perceived health disparities. Studies in Canadian health care contexts have documented experiences of microaggressions, limited promotion opportunities, and cultural isolation among racialized or visible minority workers (Jefferies et al, 2022a; Jefferies et al, 2022b). Addressing instances of microaggressions, constrained advancement, and related workplace isolation is central to both interpreting and potentially remedying the perceived health disparities observed in this study.

4.7 Policy Recommendations

The results identify a critical need for policy interventions aimed at reducing health inequities among immigrant and racialized or visible minority health care workers in Canada. These recommendations target systemic, organizational, and individual levels of action.

- (1) *Strengthen Workforce Equity and Inclusion Frameworks:* Federal and provincial health ministries should establish standardized frameworks for monitoring and addressing inequities in the health care workforce. These frameworks should mandate the collection and public reporting of disaggregated data by race/ethnicity, immigration status, and

occupation. Embedding equity metrics into accreditation or funding criteria would incentivize institutions to actively reduce disparities in health, workload, and career advancement.

- (2) *Enhance Occupational Health and Safety Supports:* Immigrant and visible minority workers, particularly those in frontline and long-term care roles, require targeted occupational health protections. Provincial labour and health authorities should expand access to ergonomic supports, mental health resources, and culturally competent counselling services.
- (3) *Address Structural Discrimination and Credential Barriers:* Regulatory bodies should streamline credential recognition for internationally educated health professionals and strengthen anti-discrimination enforcement in recruitment and promotion. Training programs for managers and supervisors must emphasize anti-racism, unconscious bias, and inclusive leadership. Integrating these into continuing professional development requirements would institutionalize cultural safety as a professional norm.
- (4) *Invest in Income and Job Security Measures:* Given the income-health gradient, policies that improve wage equity and employment stability among lower-status health workers are needed. This includes expanding permanent full-time positions, providing wage harmonization across care settings, and ensuring paid sick leave and benefits coverage.
- (5) *Support Longitudinal Research and Surveillance:* Ongoing monitoring of health disparities within the health care workforce is essential. Federal funding bodies should prioritize longitudinal and mixed-methods studies to track the evolving health impacts of structural inequities and evaluate the effectiveness of workplace interventions over time.

4.8 Conclusion, Limitations, and Future Areas of Research

4.8.1 Conclusion

This study makes three contributions that extend the current evidence base on health care worker (HCW) well-being. First, it provides design-based, population-relevant estimates of perceived general health using logistic regression. By aligning measurement with national indicator frameworks (self-rated general health and perceived health), the findings speak directly to workforce surveillance and policy planning. Second, the study advances a joint-status analysis of immigrant and visible minority status within the HCW workforce, distinguishing combined-category comparisons of this kind from a formal statistical interaction test. Rather than treating immigration or visible minority as isolated covariates, it demonstrates that their joint category is associated with the highest odds of poor/fair health, net of demographic, occupational, and other health controls. Third, the study integrates occupational structure into the equity lens, showing how role and setting relate to health alongside social position.

Additionally, this study provides evidence of perceived health disparities within Canada's health care workforce, revealing that immigrant and visible minority health care workers face disproportionately higher odds of reporting poor or fair perceived health. The findings underscore how social determinants associated with both immigrant and visible minority status affect the health status of those care workers negatively. The study also highlights that socioeconomic and occupational gradients continue to influence health within this sector. Addressing these disparities is essential for both ethical and practical reasons to ensure a healthy, resilient workforce. Improving the health of health care workers, particularly those who are visible minority or immigrants, requires coordinated, multi-level action and policies that promote

equitable working conditions, fair remuneration, inclusive institutional cultures, and access to occupational health supports.

4.8.2 Limitations

A few boundaries define the scope of these findings. Several limitations should be acknowledged when interpreting the findings of this study. First, the outcome is self-rated perceived health — a validated, policy-relevant indicator that, by design, reflects respondents' own appraisal of their health and may therefore vary with cultural norms and reporting thresholds across groups. Consequently, the measure may capture both physical and psychosocial dimensions of health in ways that vary across groups.

Second, adjusting for perceived mental health carries a risk of overadjustment. This covariate was included to isolate the association between immigrant/visible minority status and perceived general health, net of psychological well-being; however, perceived mental health is conceptually close to perceived general health, which raises the possibility that it does not function purely as a confounder. This is a recognized concern in the broader methodological literature on covariate selection in social epidemiology (Schisterman et al., 2009; van Zwieten et al., 2022): to the extent perceived mental health instead lies on the causal pathway between social position and perceived general health, the reported associations should be interpreted as conservative estimates. Future analyses of these data should report models with and without perceived mental health as a sensitivity check.

Additionally, despite the application of survey weights to improve representativeness, the data may still underrepresent certain subgroups, particularly recently arrived immigrants or temporary workers who may not be captured in national surveys. Similarly, small sample sizes

for certain occupational or regional categories limited the precision of some estimates, potentially attenuating significant relationships. Moreover, although the models adjusted for several key covariates, including income, occupation, and region, unmeasured confounders such as psychosocial stress could further explain health disparities. Lastly, the study does not directly test whether minority/immigration status is associated with lower-level work placement within institutions or with income differentials in this sample. Without this explicit analysis, the observed health disparities cannot be accurately decomposed into those attributable to social position, such as immigrant/visible minority status, differential occupational placement/setting, or income-related material resources. Given that self-rated/perceived health integrates overall life circumstances, these job and income channels are substantively important but remain underexamined here.

4.8.3 Future Areas of Research

Future research should build on these findings through longitudinal and mixed methods designs that integrate quantitative data with in-depth qualitative accounts of immigrant and visible minority health care workers' experiences. Linking administrative health data with workforce surveys could also strengthen causal inference and reduce reporting bias. Additionally, evaluating the effectiveness of equity-focused workplace interventions over time would provide critical evidence to guide policy and organizational reforms aimed at promoting health equity within Canada's health care workforce. Future work should also explore associations between immigrant/visible minority status, occupational placement, and income with the same survey design, and include an assessment of additional pathways that impact HCWs' health outcomes as well as how much the observed disparities operate through occupational structures and income.

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Chapter 5: Concluding Thoughts

5.1 Introduction

This dissertation included an integrated analysis of equity issues concerning personal care workers, migration-related health policy, and the health-care workforce in Canada, during and after the COVID-19 pandemic. While these domains may seem like discrete topics, the dissertation demonstrates that they are co-produced: the organization of PSWs in eldercare, the policy architecture that governs refugees' access to health care, and the social determinants of health among immigrant and visible minority health care workers (HCWs) jointly shape population health. Drawing on qualitative evidence about job quality in eldercare (Chapter 2), a theoretically informed policy analysis of the Interim Federal Health Program (IFHP) (Chapter 3), and design-based estimates of perceived health (PH) within Canada's HCW workforce (Chapter 4), this dissertation identifies common mechanisms that materially produce health disparities and influence health system resilience, which include employment precarity, social position, and occupational impacts. This argument, introduced in Chapter 1, maintains that labour conditions, migration policy, and institutional arrangements do not operate independently but combine to structure unequal health outcomes, with each empirical chapter substantiating one link in that shared structural chain.

The three case studies in this dissertation informed us of the following findings: first, the conditions under which care is provided are health determinants in their own right: when PSWs work understaffed shifts with compressed routines and limited supports, the consequences are borne by workers and care recipients alike, a pattern corroborated quantitatively in Chapter 4, where personal support workers and care aides show among the highest odds of poor/fair

perceived health of any health care occupation (Section 4.6.2). Second, refugees' health care coverage is a population health instrument, not simply a government expenditure with no lasting impacts: IFHP exclusions and security-oriented access rules create avoidable downstream costs and inequities that reverberate across communities and institutions (Chapter 3). Third, the joint status of immigrant and visible minority status is associated with the greatest odds of poorer PH among HCWs, even after adjusting for demographic, socioeconomic, occupational, mental health, and regional factors (Chapter 4).

Thus, this dissertation converges on some actionable insight that includes: improving job quality for PSWs, ensuring equitable refugee health care coverage, and advancing equity for immigrant and visible minority HCWs. They are mutually reinforcing strategies that will benefit population health and the health of health care systems in Canada. Collectively, there needs to be more equitable social policies aimed at improving and enhancing health equity, such as stabilizing workforce capacity, which will ultimately help to safeguard the quality and continuity of care in Canada.

5.2 Summary of Main Findings

Across the three studies in this dissertation, the central finding is that policies, social position, and institutional arrangements allocate risks and resources in ways that produce or at least influence measurable health inequalities.

The qualitative study of PSWs' job quality shows that long-standing deficits like low and uneven pay, precarious job tenure, lack of benefits, and high physical and emotional demands were magnified by pandemic conditions. Participants described cascading effects of staffing shocks: infections and isolation orders created sudden capacity deficits for staff; deficits

compressed care routines; compression of care routines increased fatigue, emotional distress, and workplace exits; and turnover further destabilized continuity of care. These dynamics were particularly acute in LTC and community/home-care settings, where time pressure, lone working, and increased infection-control responsibilities reconfigured daily work. The study's data analysis with the OECD Job Quality Framework argues that PSWs' job quality can be improved through more equitable measures, such as better staffing ratios, higher compensation standards, and increased regulation and relevant training.

The policy review of IFHP reforms identified differential inclusion criteria as a structuring logic. Eligibility is tiered by status and mediated by surveillance and documentation requirements that function as access barriers. The 2012 IFHP cuts reduced benefits for many refugees and refugee-claimants; the 2016 restorations broadly reinstated coverage but did not retroactively remediate prior harms. The analysis, grounded in social justice theory and migration studies, concludes that restricting coverage is ethically unsound and practically counterproductive, displacing costs to emergency departments and provincial budgets while worsening health outcomes, especially for women and children (Chapter 3). The study recommends retroactivity for restorations, language assistance, health care provider education, equity-oriented impact assessments, and the inclusion of migrants in immunization and public-health planning. All these measures will prevent the reproduction of inequities that are caused by policy planning and policy design.

The quantitative analysis contributes original evidence on perceived health disparities among HCWs. Using national survey data and survey-weighted logistic models, the chapter shows: visible minority HCWs have higher odds of poor/fair PH than non-visible minority peers;

immigrant HCWs have higher odds than non-immigrants; and, the joint status of immigration and visible minority status is associated with the highest odds of poor/fair PH, net of confounding variables. The models also recover familiar gradients in social and health research, namely, older age and lower household income predict worse PH. The research documented heterogeneity by occupation (e.g., elevated risk among nurses relative to physicians) and by province/region. These results situate workforce health within the broader literature on social determinants of health, while showing that even within a professional sector, social and structural positioning remains consequential for health. Importantly, the study calls for sustained surveillance and evaluation to clarify pathways (e.g., discrimination, differential assignment to high-risk roles, shift and scheduling control), as well as the need to test whether equity-focused organizational reforms can narrow the observed gaps.

Jointly, the following three overarching insights emerged:

1. *Institutional rules are health determinants.* Staffing norms, eligibility criteria, and oversight practices channel exposures and protections, shaping worker and patient outcomes. PSW job quality depends on funded staffing ratios, employment standards, and training/credential systems; refugee access hinges on policy choices about who counts as eligible and under what conditions; and, HCW health differences trace to organizational placement, protections, and cultures among other factors.
2. *Joint status matters.* The largest observed disparity appears at the joint category of immigrant and visible minority status among HCWs, underscoring that these are not isolated demographic markers but co-occurring social determinants of health (SDoH) that shape exposure, working conditions, and access to protection. That pattern echoes the

gendered, visible minority composition of support roles (including PSWs) and the stratifying effects of status in refugee health policy—each a determinant that compounds when layered with the others. Equity efforts that proceed along a single determinant will therefore miss the compounding determinants and risks identified in these studies.

3. *Workforce health and population health are linked.* When PSWs' work is precarious and understaffed, care quality and safety suffer; when refugee access is administratively constrained, conditions worsen until care is sought in costlier settings; when immigrant and visible minority HCWs experience disproportionate strain, the risk of attrition rises, which impacts the overall health care system's capacity for care.

5.3 Summary of Policy Recommendations

This section will provide a summary of policy recommendations discussed at length for each of the three study-based chapters. Overall, the recommendations form an integrated argument to inform a need for equity in the domain of health more generally.

First, ensure PSW job quality is a core and official program target. It is important to begin where retention begins, which involves job compensation and job security. This includes the need to raise and harmonize wages across settings, expand permanent full-time positions, guarantee paid sick leave, and limit involuntary part-time and casualization. Without income stability, turnover is bound to persist and continue to be an issue that plagues the overall care of the elderly. Next, fund and enforce safe staffing and realistic workload. Ratios should reflect resident acuity in long-term care (LTC) and caseloads need to be realistic in home/community care as anything less institutionalizes corner-cutting and contributes to emotional distress for care staff. Additionally, it is important to build training, regulation, and career ladders that

standardize competencies, and strengthen oversight. Ensure the availability of mental-health and occupational health support through various eldercare organizations and not treat them as discretionary (e.g., counselling, debriefs, ergonomic equipment, protections from violence). Finally, ensure voice and participation for PSWs in operational and policy decisions, particularly for infection control and emergency preparedness. These actions map directly onto the OECD pillars of earnings, labour-market security, working environment, and should yield significant improvements in safety, continuity, and care quality for PSWs.

Second, consolidate equitable refugee coverage and de-securitize access to health and health care coverage by treating the IFHP as a tool for prevention. First, make restorations retroactive to mitigate documented harms to those who arrived during the restriction period. Second, invest in language services and navigation supports, as any health coverage that cannot be understood or used is not a benefit. Third, promote provider education on eligibility, billing, and service delivery to reduce administrative refusal and ease the administrative burden for health care workers. Lastly, include migrants in immunization and public health planning to align coverage with collective protection to manage and improve population-level health. This also involves the need to adopt and ensure a non-exclusion principle for essential services during outbreaks. As discussed at length, these policy recommendations are both administratively feasible and fiscally prudent, given the evidence on cost displacement from deferred primary care.

Third, advance equity and health for immigrant and visible minority HCWs, beginning with measurement and accountability. Include the need to mandate disaggregated indicators (by immigrant and visible minority status) for workload, injury, scheduling, advancement, and health

outcomes, and link improvements to accreditation and funding. Additionally, deploy targeted occupational health, mental health and psychosocial supports, especially in high exposure and frontline care settings. This includes mandating predictable scheduling, ergonomic investments, and culturally responsive mental-health resources. Of critical importance, address structural discrimination and credentialing through accelerated recognition pathways, enforcement of anti-discrimination standards, inclusive leadership training, and transparent promotion criteria. Moreover, reduce the income-health gradient by harmonizing wages across settings and expanding stable positions for more precarious occupation groups (e.g., PSWs and care aides). This includes the need to track results longitudinally to determine whether inequity gaps narrow as reforms take hold.

Overall, in order to promote health for both HCWs and those accessing care, it is important to tackle existing shortcomings using a multifaceted approach as many of the existing problems are interrelated. Improving PSW job quality reduces turnover in settings where immigrant and visible minority workers are concentrated and thus supports equity goals. Equitable refugee coverage reduces avoidable emergency room use, easing pressure on frontline teams. Equity interventions redistribute organizational risk, making services more resilient and better prepared for future public crises. The strategic logic is simple: by protecting those who provide care and those who are new to accessing care, the entire system functions better.

5.4 Summary of Key Contributions

5.4.1 Substantive Contributions

The overall dissertation contributes an account of how policy design and labour institutions generate health outcomes. Chapter 2 highlights the ways that staffing levels, employment duties, and pandemic policy arrangements can shape PSW well-being and care quality. It reframes PSW job quality as an actionable property of the health care system that is responsive to compensation policy, staffing investments, and regulatory design. Chapter 3 situates refugee coverage within a justice-oriented framework and shows how border security rationales and differential inclusion create inequities that likely increase downstream costs and worsen outcomes, especially for women and children. Chapter 4 quantifies perceived health disparities across social locations within the health care workforce, and demonstrates that the combined category of immigrant and visible minority status has the most adverse association with PH, net of controls.

5.4.2 Other Contributions

Bringing together migration studies, social-justice theory, the sociology of work, and the social determinants of health, the dissertation clarifies how status hierarchies, social determinants, and organizational placement all produce cumulative burdens on health. In policy terms, the work argues for moving beyond “equal treatment” rhetoric toward equity-oriented allocation that addresses differential exposure and needs rather than a one-size-fits-all approach. Additionally, the dissertation demonstrates the value of using multiple methods to explore and learn more about complex social problems: a qualitative study structured using the OECD Job Quality Framework to interpret PSWs’ accounts of work and job quality (Chapter 2); a policy review that

links theory to concrete institutional rules and administrative procedures (Chapter 3); and, a survey-based quantitative regression analysis that produces population relevant estimates of joint-status health disparities, informed by the social determinants of health (Chapter 4). The mixed research design improves external validity by showing how the same inequity-producing mechanisms appear across empirical registers and levels of analysis, micro (worker experiences), meso (organizational practices), and macro (federal eligibility and surveillance logics).

5.4.3 Policy Relevance and Evaluability

A further contribution is translational: each study of this dissertation has articulated specific, monitorable changes (e.g., staffing ratios, wage parity across settings, retroactivity for IFHP restorations, language access, credential recognition, disaggregated workforce metrics) that can be implemented and evaluated with routine data. This is critical for policy adoption, where attention and resources are scarce and future reforms must justify feasibility, evidence base, and return on investment for taxpayers. Additionally, the dissertation advances the need for an integrative framework, where treating labour policy in care, refugee coverage rules, and workforce equity as co-determinants of population health are important. This focus on integration implies that single-focus reforms will be blunted if others lag. For example, equitable coverage without workforce stabilization can still overload frontline services; staffing investments without equity measures can leave the highest-risk subgroups unprotected. Policy coherence across these domains is not only desirable, but also a key precondition for sustainable gains in health and health care system performance overall in Canada.

5.5 Suggestions for Future Research

Building on the dissertation's findings, several future research avenues became apparent. For the eldercare sector, larger-scale and mixed-methods studies should assess the prevalence and distribution of precarious employment, burnout, and low pay across regions and sub-sectors, ideally through comparative designs that examine policy variation across provinces and over time (e.g., wage and staffing levels, and mandates). Longitudinal follow-ups are particularly important to evaluate whether recent reforms in Ontario, such as permanent wage increases and staffing-ratio initiatives, produce measurable improvements in retention, safety, and job satisfaction, or whether core challenges persist post-pandemic.

For health care policy concerning vulnerable social groups, future work should conduct equity-oriented evaluations on policies at both federal and provincial levels. Future research should assess how concurrent policies (e.g., in the case of IFHP, surveillance practices, language access, and settlement support) interact with relevant rules to shape access and outcomes, as well as examine health care utilization and health outcomes to identify residual gaps and unintended effects. Such evaluations should incorporate population-level public-health planning for these groups to address policy gaps revealed during the widespread disruptions of the COVID-19 pandemic.

Future research should also pair longitudinal survey designs with qualitative inquiry to trace how institutional changes affect the health of employees with immigrant and/or visible minority backgrounds over time, and to unpack mechanisms such as discrimination, microaggressions, and constrained advancement. Linking administrative health records with workforce surveys would strengthen causal inference, address reporting bias, and improve

coverage of underrepresented groups. Lastly, ongoing surveillance should evaluate the effectiveness of equity-focused workplace interventions such as wage fairness reviews, credential recognition reforms, targeted occupational health supports, and inclusive leadership training in order to determine which combinations sustainably reduce disparities in perceived and self-rated health.

5.6 Final Thoughts

Across qualitative, policy, and quantitative strands, the global finding is clear: worker conditions, marginalized populations' health care access, social position, and institutional policies are all core determinants of population health. When care aides have secure employment, safe staffing, standardized training and regulations, and embedded mental-health supports, the system delivers safer, more continuous, and more humane care. When refugees receive timely, equitable, and navigable coverage reinforced by language supports, preventable crises are averted and acute-care pressures ease. When immigrant and visible minority health care workers are protected through fair routine measurement and anti-discrimination enforcement, avoidable health risks decline, and workforce health outcomes improve. These insights point to a need for social policy reform that involves investing in compensation and stability for frontline staff; enforcing realistic workload and staffing standards; building career ladders and voice in decision-making; guaranteeing comprehensive, stable health coverage that is simple to use; and institutionalizing equity through data, accountability, and enforcement. These steps are implementable and evaluable. Thus, equity is efficiency, prevention is protection, and policy coherence across sectors and health care coverage are the necessary conditions for durable improvement in both population health and care quality for Canadians.

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APPENDIX: Supplementary Statistical Detail for Table 6

This appendix accompanies **Table 6** and reports standard errors and 95% confidence intervals for all coefficients presented.

Variable	Model 1	Model 2	Model 3
Visible minority status			
Not a visible minority (ref.)	—	—	—
Visible minority	SE = .22 95% CI [1.23, 2.11]	—	—
Not stated	SE = .49 95% CI [1.03, 3.04]	—	—
Immigrant status			
Non-immigrant (ref.)	—	—	—
Immigrant or non-permanent resident	—	SE = .21 95% CI [1.19, 2.03]	—
Not stated	—	SE = .36 95% CI [0.65, 2.16]	—
Immigrant and visible minority status			
Non-immigrant, not visible minority (ref.)	—	—	—
Non-immigrant, visible minority	—	—	SE = .37 95% CI [0.70, 2.23]
Immigrant, not visible minority	—	—	SE = .25 95% CI [0.57, 1.61]
Immigrant, visible minority	—	—	SE = .26 95% CI [1.28, 2.32]
Non-immigrant, visible minority status not stated	—	—	SE = .50 95% CI [0.51, 2.72]
Immigrant, visible minority status not stated	—	—	SE = .89 95% CI [1.04, 4.88]
Immigrant status not stated, not visible minority	—	—	SE = .24 95% CI [0.24, 1.31]
Immigrant status not stated, visible minority	—	—	SE = .63 95% CI [0.41, 3.38]

Immigrant and visible minority status not stated	—	—	SE = .99 95% CI [0.79, 5.29]
Age group			
18 to 34 years (ref.)	—	—	—
35 to 44 years	SE = .25 95% CI [1.00, 2.00]	SE = .24 95% CI [0.95, 1.89]	SE = .24 95% CI [0.98, 1.95]
45 to 54 years	SE = .36 95% CI [1.49, 2.92]	SE = .33 95% CI [1.40, 2.73]	SE = .35 95% CI [1.43, 2.81]
55 years and older	SE = .34 95% CI [1.45, 2.80]	SE = .30 95% CI [1.30, 2.49]	SE = .33 95% CI [1.39, 2.70]
Gender			
Male (ref.)	—	—	—
Female	SE = .22 95% CI [0.96, 1.82]	SE = .21 95% CI [0.93, 1.75]	SE = .21 95% CI [0.95, 1.77]
Total household income			
Under \$100,000 (ref.)	—	—	—
\$100,000 to \$149,999	SE = .10 95% CI [0.42, 0.82]	SE = .10 95% CI [0.42, 0.82]	SE = .10 95% CI [0.42, 0.82]
\$150,000 or more	SE = .11 95% CI [0.47, 0.92]	SE = .11 95% CI [0.47, 0.92]	SE = .11 95% CI [0.47, 0.92]
Not stated	SE = .14 95% CI [0.62, 1.16]	SE = .14 95% CI [0.64, 1.19]	SE = .13 95% CI [0.63, 1.15]
National occupation classification (NOC)			
Physician (ref.)	—	—	—
Nurse	SE = .36 95% CI [1.24, 2.68]	SE = .34 95% CI [1.21, 2.56]	SE = .35 95% CI [1.21, 2.62]
Personal support worker/care aide	SE = .44 95% CI [1.40, 3.18]	SE = .43 95% CI [1.36, 3.08]	SE = .43 95% CI [1.34, 3.08]
Other	SE = .22 95% CI [0.79, 1.66]	SE = .21 95% CI [0.76, 1.59]	SE = .22 95% CI [0.77, 1.64]
Province or region			
Atlantic provinces (ref.)	—	—	—
Quebec	SE = .15 95% CI [0.69, 1.30]	SE = .15 95% CI [0.69, 1.31]	SE = .15 95% CI [0.68, 1.30]

Ontario	SE = .19 95% CI [1.02, 1.77]	SE = .19 95% CI [1.03, 1.78]	SE = .19 95% CI [1.01, 1.76]
Manitoba	SE = .11 95% CI [0.60, 1.04]	SE = .11 95% CI [0.60, 1.05]	SE = .11 95% CI [0.59, 1.04]
Saskatchewan	SE = .10 95% CI [0.58, 0.99]	SE = .10 95% CI [0.58, 1.00]	SE = .10 95% CI [0.56, 0.97]
Alberta	SE = .11 95% CI [0.57, 1.02]	SE = .11 95% CI [0.58, 1.03]	SE = .11 95% CI [0.57, 1.02]
British Columbia	SE = .15 95% CI [0.85, 1.44]	SE = .15 95% CI [0.86, 1.47]	SE = .15 95% CI [0.84, 1.45]
Perceived mental health			
Excellent (ref.)	—	—	—
Very Good	SE = 0.32 95% CI [0.41, 1.75]	SE = .32 95% CI [0.40, 1.77]	SE = .32 95% CI [0.40, 1.76]
Good	SE = 1.12 95% CI [1.88, 6.55]	SE = 1.11 95% CI [1.87, 6.52]	SE = 1.12 95% CI [1.88, 6.57]
Fair	SE = 7.74 95% CI [13.11, 45.45]	SE = 7.75 95% CI [13.10, 45.47]	SE = 7.89 95% CI [13.34, 46.31]
Poor	SE = 26.73 95% CI [38.17, 151.46]	SE = 27.10 95% CI [38.76, 153.62]	SE = 27.46 95% CI [39.16, 155.56]