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A PROGRAM FOR RESEARCH ON

SOCIAL AND ECONOMIC DIMENSIONS OF AN AGING POPULATION

Organizational Change and the Health and Well-Being of Home Care Workers

Margaret Denton
Isik Urla Zeytinoglu
Sharon Davies

SEDAP Research Paper No. 110

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Requests for further information may be addressed to:
Secretary, SEDAP Research Program
Kenneth Taylor Hall, Room 426
McMaster University
Hamilton, Ontario, Canada
L8S 4M4
FAX: 905 521 8232
e-mail: qsep@mcmaster.ca

ORGANIZATIONAL CHANGE AND THE HEALTH AND WELL-BEING OF HOME CARE WORKERS

MARGARET DENTON
ISIK URLA ZEYTINOGLU
SHARON DAVIES

SEDAP Research Paper No. 110

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Organizational Change and the Health and Well-Being of Home Care Workers

Final Report

Submitted to: Workplace Safety and Insurance Board (WSIB)

June, 2003

Principal Investigator: **Dr. Margaret Denton**
Director, McMaster Centre for Gerontological Studies
Professor, Gerontological Studies & Department of Sociology
McMaster University
1280 Main St. West, KTH Room 226
Hamilton, Ontario, Canada L8S 4M4
Tel: 905-525-9140 ext. 23923
Fax: 905-525-4198
E-mail: mdenton@mcmaster.ca

Co-investigators: **Dr. Isik Urla Zeytinoglu**
Professor, Human Resources and Management Area
MGD School of Business, McMaster University
E-mail:zeytino@mcmaster.ca

Sharon Davies
Research Associate
McMaster Centre for Gerontological Studies
McMaster University
E-mail:daviess@mcmaster.ca

Participating Agencies and Union Locals

Bayshore Health Care (merged with Gentiva)

Care Plus

Comcare

Community Rehab

Hamilton-Wentworth Community Care Access Centre
Union: OPSEU Local 274

St. Elizabeth Health Care

SEN Community Health Care
Unions: CUPE Local 4800, ONA Local 9,
PNFO Local 32, SEIU Local 532

Therapy Health Care

Therapy Specialties

VHA Health and Home Support Services
Union: SEIU

Victorian Order of Nurses
Union: OPSEU Local 269

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Organizational Change and the Health and Well-Being of Home Care Workers

M. Denton, I.U. Zeytinoglu, & S. Davies

Abstract

Objective: The objective of this research is to study the impact of health care restructuring and other organizational changes on the mental and physical health of home care workers.

Methods: This study covers 11 agencies and 7 union locals. We interviewed 59 key decision-makers, 171 workers in 29 focus groups, and surveyed 1,311 workers (70% response rate). Qualitative data are analyzed for themes and quantitative data analysis consists of descriptive statistics and associations between variables.

Results: The restructuring of the health care sector and organizational change have increased stress levels and musculoskeletal disorders of home care workers. Physical health problems among this workforce are much higher than the comparable group in the Canadian population. Restructuring and organizational change are significant factors in decreasing job satisfaction, while increasing absenteeism rates, fear of job loss, and propensity to leave.

Conclusions: Occupational health problems experienced by these workers are preventable. It is important to acknowledge that occupational stress can result from incremental changes in the work and external work environment, affecting physical health, job dissatisfaction, absenteeism, and propensity to leave. Sufficient government funding to provide services, avoiding continuous changes in the work environment, and creating supportive work environments can positively contribute to workers' health.

ORGANIZATIONAL CHANGE AND THE HEALTH AND WELL-BEING OF HOME CARE WORKERS

M. Denton, I.U. Zeytinoglu & S. Davies

SUMMARY

The **purpose** of this research program is to uncover and provide new information to improve the prevention of work related injury and illnesses in home care work. This study focuses on home care workers, which include both visiting home care workers (personal support workers, nurses and therapists who work directly in the client/consumer's home) and office home care workers (case managers, coordinators, office staff, supervisors and managers).

Home care has recently been restructured from a non-competitive system of home health care delivery by non-profit and for-profit organizations to a system of 'managed competition' [through requests for proposals (RFP)], where both non-profit and for-profit agencies have to compete for contracts to deliver home health care services. Further, the restructuring of health care has shifted much of the burden of health care to the community sector without a corresponding shift in the level of funding for community health care agencies.

The **objective** of this research is to study the impact of health care restructuring and other organizational changes on the mental and physical health of home care workers. By mental health we refer to stress and burnout. By physical health we refer to occupational illnesses such as musculoskeletal disorders (MSDs) and injuries. Job satisfaction, absenteeism, job insecurity and propensity to leave are examined as individual and organizational outcomes.

The research design incorporates both qualitative and quantitative data gathering. We began with 59 interviews with agency executive directors, managers and union representatives to develop an understanding of health and safety issues in their agencies. Of interest was the relationship of organizational change associated with health care restructuring in general, and long-term care restructuring in particular. This was followed with a series of 29 discussion groups with employees from the participating agencies to gather their input on these issues. Information gathered through the interviews and the discussion groups, a review of current literature and knowledge gained from our earlier study informed the development of a questionnaire that was administered to all 1,949 employees of the home care agencies. In total 1,311 home care workers responded to the survey, representing a close to 70% response rate.

Results show that home care workers have high levels of stress and burnout. On the positive side, workers in all occupational groups in this sector show high levels of self-esteem and mastery. In terms of physical health problems, a number of diagnosed health problems are common among this workforce, such as back pain, arthritis and rheumatism, migraine headaches, high blood pressure, stomach and intestinal disorders, and cancer. Physical health problems among this workforce are much higher than the comparable group in the Canadian population. Another occupational health problem for this workforce is workplace harassment and violence. Taking into consideration that these workers are primarily employed in elderly or sick clients' homes, it is common for these workers to experience unacceptable racial/ethnic or sexual comments or

harassment. Workers have high levels of job insecurity and are afraid of losing their jobs or workplaces closing because of their agency not getting the contract. Still, the workers are dedicated to their agencies and show low levels of propensity to leave. However, managers and supervisors are having problems managing the increasingly stressed, dissatisfied home care workforce. Many respondents are critical of the restructuring and managed competition process.

Our study shows that restructuring and organizational change in the home care sector has contributed to the deteriorating health of workers. The business-like work environment, lack of resources in the home care sector, government's budget cuts, wage inequalities, work intensification, and perceived decline in the quality of care given to clients, are all taking their toll on these workers. Their stress levels are increasing and for some, burnout is a significant problem. The restructuring and organizational change factors are also associated with increased levels of diagnosed and self-reported MSDs, job dissatisfaction, absenteeism, fear of job loss, and propensity to leave the workplace. In addition, the poor physical work environment, such as safety hazards in clients' homes, repetitiveness of the job, and poor psychosocial work environment, such as lack of organizational (and supervisory) support, low co-worker support, lack of control over work, and lack of time to provide emotional support to clients, are all factors associated with increased levels of stress, burnout, MSDs, job dissatisfaction, absenteeism, feelings of job insecurity, and propensity to leave their agency.

In conclusion, our results show that occupational health problems experienced by workers in this study are preventable. It is important to acknowledge occupational stress as resulting from incremental changes in the work and external work environment, and the resulting effects on physical health, job dissatisfaction, absenteeism, and propensity to leave the workplace. Sufficient government funding to provide services, avoiding continuous changes in the work environment, and making rationale restructuring decisions based on input from all stakeholders can contribute to healthier workplaces and healthy workers.

Our results can assist employers, policy makers and workers in preventing work-related diseases and injuries. This research uncovered and provided new information to all stakeholders to improve the prevention of work-related injuries and illnesses. We hope our results can assist the WSIB to improve their policy and process by providing further evidence on how organizational change, restructuring, and management policy dictated by the government can affect workplaces, work practices and workers' health.

As we conduct further statistical analysis of our data and as our research is published, we anticipate that our findings will make significant contributions to policy formation and professional practices in Canada and elsewhere. We also hope that the results of this project can be used to influence policy formation in home care sector at the local, provincial and international levels. Agencies and unions working with us are anxious to assess the impact of changes made in their organizations, and of health care restructuring on the health and well-being of their employees. We encourage them to use the outcomes of this research to make appropriate work changes that can minimize disabilities and work related illnesses such as stress, burnout and MSDs. Our research contribution will be especially important as home care reform comes to the forefront of policy debates in Ontario and Canada.

1. PURPOSE AND OBJECTIVES OF THE RESEARCH

The **purpose** of this research program is to uncover and provide new information to improve the prevention of work related injury and illnesses in home care work. This study focuses on home care workers, which include both visiting home care workers (personal support workers, nurses and therapists who work directly in the client/consumer's home) and office home care workers (case managers, coordinators, office staff, supervisors and managers). Our previous research funded by SSHRC has shown that home health care workers are satisfied with their jobs but are at risk for chronic stress problems, exhaustion, musculoskeletal disorder (soft tissue injuries), workplace injuries and accidents.[1] Furthermore, these health care problems have been linked to the social organization of their work.[2-7]

Home care has recently been restructured from a non-competitive system of home health care delivery by non-profit and for-profit organizations to a system of 'managed competition' [through request for proposals (RFP)] where both non-profit and for-profit agencies have to compete for contracts to deliver home health care services.[8] Further, the restructuring of health care has shifted much of the burden of health care to the community sector without a corresponding shift in the level of funding for community health care agencies.[8]

Health care restructuring over the past ten years has changed the nature of home care work in a number of important ways. Home care agencies have re-organized the work process. They have reorganized the provision of care in homes from a system where individuals work alone in the community to a system where individuals work in neighbourhood teams. Managed competition has resulted in increased job insecurity, intensification of work, and the growth of non-standard work (self employment as contract work, multiple jobs, part-time jobs and casual jobs). These organizational changes have resulted in changes in work environments for home care workers.

Turnover in home care organizations is high and there is a shortage of visiting nurses and personal support workers, both nationally and in many communities including Hamilton. Reasons for this shortage are varied and complex. Managed competition has increased jobs, but people are not attached to the same organization for lifelong work. Many visiting nurses and personal support workers who have college education prefer to work in hospitals and other institutions that may provide better working conditions. In good economic conditions, personal support workers find jobs in other sectors of the economy. There is a lack of human resources planning for nurses resulting in a current shortage of nurses; the average age of nurses in Ontario is 45. Many therapists who once worked for non-profit agencies are now self-employed.

The **objective** of this research is to study the impact of health care restructuring and other organizational changes on the mental and physical health of home care workers. By mental health we refer to chronic stress, exhaustion, burnout and job satisfaction. By physical health we refer to occupational illnesses such as musculoskeletal disorders, workplace accidents, and loss time injuries. The **scope** of this project is to examine home care workers in the New City of Hamilton.

2. HEALTH CARE RESTRUCTURING IN ONTARIO

2 a) The Home Care Context

Health care restructuring has been occurring at a rapid rate in Canada, but with little research to document any long range impacts of the changes.[8] Restructuring is also taking place in other countries. Responding to increasing health care costs, deficit financing and the aging of the population, countries such as Canada, the United States, the United Kingdom, Sweden, Germany, France, and the Netherlands are exploring new cost-efficient health care models.[9-11] These reforms are attempting to shift the locus of care from expensive acute care institutions into the community and home based-settings and involve reforms to both the hospital and home-based health care systems.[12] As care is moved from the institution into the community, the home care sector has experienced tremendous growth. In Ontario, the provincial government has reduced health care spending by closing hospitals and hospital beds, de-listing drugs, charging user fees, privatizing services, de-insuring services, increasing waiting lists, expanding outpatient clinics and day surgery, and leaving more care to the community.[13-15]

Home care is an integral component of long-term care in Ontario, described by Havens[16] as a "Continuum of Care", a mix of health and social services. But, despite its wide range of services, home care in Ontario has been plagued with problems of fragmentation, accessibility, and equity.[17, 10] Some of these problems have been addressed in attempts to reform long-term care in Ontario since the late 1980s.[18-22] Common to all of the proposed reforms is the emphasis on community as opposed to institutional care and the movement toward a "one-stop shopping" approach to long-term care in Ontario.

As of October 1, 1997 the Ontario Government implemented a plan which involved the replacement of 74 Home Care and Placement Co-ordination Programs in the province with 43 Community Care Access Centers.[23-25] The new CCACs are a one-stop shopping approach to service delivery, based on the principle of competition. Both for-profit and not-for-profit home care agencies bid for contracts with the CCAC to provide services. The agencies who can provide quality care at the lowest cost will win the contracts.[26] The CCACs and agency's relationship has become more business-like, one of purchaser and supplier.[27] Some fear that for-profit agencies will drive the prices of services down, while compromising the quality of services.[23]

Competition has serious implications for non-profit health care agencies. To date, agencies have lost many of their employees, agencies have closed and the future of each agency is uncertain. This degree of uncertainty will likely have a negative impact on the health and well-being of home care workers. The last few years were a transition period in home care in Hamilton. Now, the home care agencies are being awarded four year contracts to deliver services, so job security is improving and the work environment is becoming more stable. Still, there is a lack of knowledge on the impact of the changes in home care and the health of home care workers. With the increase in demand for their services, agencies need to know how to keep their employees healthy and to attract employees to the home care sector.

In a recent study on home care which included input from over 1000 people from home care organizations, advocacy groups, caregiver organizations, health associations, trade unions, and

researchers, the Canadian Association of Retired Persons (CARP)[8] found that the number one concern in home care is human resources. In fact, they state "people working in the home care environment are over-extended and under considerable stress from difficulties in the workplace..." [8, p. iii] The second most important issue was inadequate funding, which results in a multitude of other problems. CARP recommends increasing research and policy direction in the home care industry. This study aims to fill this need.

2 b) Why is the need or issue a high priority?

Research on the impact of restructuring and organizational change in home care has been identified as high priority by academic researchers,[28-32] the Canadian Association of Retired Persons [8] and by the home care agencies we partnered with in this research project. The health care sector is one of the most labour-intensive sectors in the Canadian economy. Good quality health care delivery is largely dependent on the quality of the staff delivering the services. It is well-known in the human resources management field that satisfied workers are more productive and efficient, and provide better quality services or goods produced. The health care sector, and particularly the home care sector division, has gone through major changes in the last decade. The resulting burnout and declining morale of the workers, staff shortages, and recruitment and retention problems are well known.[32] Non-standard and flexible employments are now common features of the work life in this and many other sectors in Canada and elsewhere.[33, 34] The issues examined here are identified in general terms, by the WSIB as areas of research. In particular, WSIB is interested in the effects on worker health and safety resulting from organizational change (such as downsizing, restructuring and privatization) and/or non-standard work (such as the self-employed, contingent workforce, multiple job holders).

Home care workers are dedicated to their jobs and clients but are over-worked and stressed to the limit, showing symptoms of negative consequences on their well-being. Nurses, therapists, personal support workers and office support staff who once worked in a secure, non-profit organization are left wondering if they will have jobs in the new system of "managed competition". Managers and supervisors are doing their best to provide care to clients and supportive work environments to employees in a volatile environment. Agencies who once worked together are now competing against one another. Recruitment and retention of staff is difficult in a competitive environment where work is based on contracts which may or may not be granted. Work is available for home care workers as long as they are willing to change workplaces. Therapists in particular, are in great demand. A recent newspaper article described the situation as a "community care crisis."[35] Because this change has occurred at such as rapid rate, the impact of this on workers' health and well-being is unknown.

Agencies and our earlier research[1, 36, 37] have identified high stress levels among their employees and an increase in loss time injuries. Further, our research[7] shows a high rate of musculoskeletal disorders among visiting home care workers. The relationship of these health problems to health care restructuring and organizational change is now being examined,[2, 3] but as yet definitive answers are not available.

It is important to understand the impact of organizational change so that policy decisions can be made to provide better working conditions for home care workers resulting in efficient, less costly

service to clients. We intend for this project to influence policy at the agency, but more importantly, at the government level which is the lead source of workplace and work environment changes. Because the reorganization of home care occurred at such a rapid rate, the implications of this change have not been documented. We feel that a study such as this could contribute to policy changes which would improve the health and well-being of home care workers who are at present, over worked, stressed and have little job security. We anticipate that our study will make an important contribution to improving the working conditions and work-related health of home care workers in the future through policy recommendations. As our research is published we anticipate that our findings will make significant contributions to policy formation and professional practices in Canada and elsewhere. Outcomes of this research can be used by agencies to make appropriate changes at work that can minimize work-related illnesses such as stress and musculoskeletal disorders and minimize disability. This contribution will be especially important as home care reform comes to the forefront of policy debates in Ontario. This study can improve WSIB policy and process by providing further evidence of how organizational and management policy, practices and workplace culture can affect health and safety at the levels of policy and the workplace itself.

3. HEALTH AND SAFETY OF HOME CARE WORKERS

3 a) Review of Existing Literature

Research on the **health** and well-being of home care workers is only beginning to develop in Canada. Up until recently, occupational health research has focused on male-dominated occupations because it was falsely believed that women's paid jobs are less hazardous than men's.[5,38-40] Research shows that paid work contributes to women's mental health problems of stress, anxiety, and depression.[42-45] Studies also show that work-related **stress** is a fundamental health issue for visiting home care workers.[1, 2, 46-48] Some effects of stress in the workplace manifest in symptoms such as nausea, fatigue, problems falling asleep, anxiety, asthma, headaches, blurred vision, backaches, heart diseases, diabetes, stomach and bowel problems, rheumatoid arthritis, cynicism, irritability, unhappiness, and burnout.[49-53]

There are numerous potential **sources of stress** for home care workers: limited control of tasks and scheduling; feelings of powerlessness and little impact with respect to agency policy; job dissatisfaction; shift work; repetitive monotonous work; difficult clients; job changes; stagnancy; poor supervision or supervisors; prejudice; sexism; employment instability; restricted social interaction with and isolation from co-workers; lack of institutional and organizational support; lack of communication; transportation difficulties; and low wages.[2, 3, 6, 36, 48, 53-59]

Research also shows that unpredictable hours of work are a source of job dissatisfaction[58] and that flexible hours of work and regular hours of work are related to **job satisfaction**[59] for home care workers. Low wages and minimal benefits are typical features of home care work[6,48, 52, 57, 60-65] and are sources of job dissatisfaction.[36, 58, 65, 66]

Caring relationships that home care workers form with their clients are positive features of the job and a source of **job motivation** and job satisfaction.[36, 63, 67,68] Often personal support workers will perform services and tasks far beyond their job descriptions for their clients, usually based upon the interpersonal relationships formed with their clients.[67, 69] One complication of the relational aspect of home care pertains to what is known as "emotional labour", or the "labour involved in dealing with other people's feelings."[70] This relational aspect of home care is considerably important for both workers and clients, but is often perceived by personal support workers to be unrecognized and devalued by the public, clients and other health professionals.[46, 71] For example, home care workers in Bartoldus, Gillery & Sturges's study[46] described the general public viewing them as "unskilled maids" who do the "dirty work" in society. Policies do not recognize the importance of emotional labour, often emphasizing the importance of completing instrumental tasks rather than the caring aspect of the job.[72] For example, when cutbacks result in reductions in time allotments for clients, personal support workers have little time to accomplish the emotional rather than the physical part of their work.[72] These types of policies are in direct contrast to the perceptions of home care workers who feel the emotional part of their work is more important and more difficult than instrumental work.[48, 72] The emotional aspect of home care work can, at times, be stressful for home care workers.[2, 48] Home care workers must deal with "difficult clients" who can be a source of stress.[53, 36] Home aides often have to deal with the stress of client and family requests and complaints[73] and "instances of abusive, bizarre, angry, stubborn, cursing, depressed, sad, forgetful, and fearful behaviour" on the part of some clients.[56, p.36]

The health and well-being of visiting home care staff is also jeopardized by their physical environment. Thomas[53] shows that the **physical health** of home care workers is at risk because they are at risk of contagious diseases, skin irritants and allergies, infections, exposure to toxic chemicals, and physical injuries from lifting clients. Home care workers are also exposed to dangerous chemicals related to laundry and cleaning tasks such as solvents, hydrocarbons, soaps, detergents, bleaches and alkalies.[74-77] Musculoskeletal disorders are one of the most significant physical health problems of home care workers.[1, 6, 7]

Unsafe homes and neighbourhoods are another hazardous aspect of the physical work environment of home care.[36, 55, 56, 78] Risks from physical, emotional and sexual violence (including intimidation, harassment, and assault)[78-81] are common safety hazards. Other work hazards include slipping on ice and traffic accidents when travelling to and from clients' homes, especially those which occur in bad weather.[2, 36, 78]

Several aspects of home care work are characterized by specific organizational working conditions. For example, literature shows that isolation is a negative aspect of the organizational environment of home care work. Workers are isolated from and are not supported from peers and supervisors.[3, 56, 57, 63-65, 72, 79] Another feature of home care organizational working conditions is not receiving adequate information regarding potentially dangerous clients.[2, 79, 80] Literature suggests that home care workers lack information regarding clients and client care plans,[3, 57, 63, 64, 79] which may threaten their safety as visiting home care workers need to be notified of potential risks associated with some clients in the community.[80, 102]

Musculoskeletal disorders have started to receive attention in women's occupational health research in the past decade.[43, 82-84] Research on musculoskeletal disorders in female-dominated home care work is almost non existent with the exception of a few studies conducted in Scandinavian countries[85, 86] and our Canadian research in this area.[5-7] Research shows that when home care workers are compared to workers in other occupations, they show a higher prevalence of musculoskeletal symptoms.[87] Health assessment and treating occupations[88,89] including physiotherapists[90] and nurses.[91, 92] have been shown to be at a high risk of musculoskeletal disorders. Office and clerical workers also report musculoskeletal disorders as a major occupational health problem.[93-96]

Research shows several physical work factors as sources of musculoskeletal disorders among home care workers. Johansson[87] shows that a "high" physical work load (of lifting heavy loads; monotonous movements; sideways turns/twisted postures; standing with a deep forward flexed trunk; and working with hands above the shoulder) is associated with musculoskeletal symptoms. For nurses, the greatest risk factor for musculoskeletal problems is a combination of job strain and high physical exertion[97-99] and for physiotherapists[90] lifting or transferring dependent patients. Office and clerical workers often work in small, cramped areas with non-ergonomic office equipment.[5,6] Most back injuries among home health aides and nurses are due to patient-related activities, involving pushing/pulling of patients or materials.[88, 92, 99]

Literature shows several **psychosocial work factors** to be associated with musculoskeletal disorders. Bongers, de Winter, Kompier & Hildebrandt,[102] Hales and Bernard,[103] and Theorell,

Harms-Ringdahl, Ahlberg-Hulten & Westin[104] suggest that increased/high workload, low/limited control at work, and lack of/low social support at work are the most common psychosocial factors related to musculoskeletal disorders. For home care workers[6, 37, 88] and nurses, work pressure[99], low social support at work[97, 105], low control and high demands at work[105] are important factors associated with musculoskeletal disorders.

Much of the research on the impact of **health care restructuring** focuses on unpaid (most often female) caregivers[106-111] and hospital employees.[106, 112, 113] In hospitals, restructuring has had a negative impact on both patient care and the health of hospital employees.[112] Hospital cutbacks have resulted in tension, stress, physical illnesses, work-related injuries, and increasing risks to health and safety in the workplace; hospital housekeeping staff have reported layoffs, non-replacement of sick staff, increasing workloads, increasing accidents, and rigid time allocations.[112]

To date, literature on the impact of health care restructuring on the health and well-being of home care workers is virtually nonexistent. A few studies show how restructuring has affected working conditions in home care. For example, in the U.S., Glazer[109] found that early hospital discharges (a result of restructuring) have increased the complexity of home care work. Home care patients are sicker than they once were and home care work is much more technical than it used to be.[109] Visiting nurses now do a variety of complex treatments and home health care aides (personal support workers) now perform many of the functions that nurses once performed.[109] Home care workers have suffered through increased workloads, stress, frustration and performing unpaid overtime in order to complete work, including more and more documentation tasks.[109] Szasz[114] also found that federal cost containment policies have resulted in increased management control and the intensification of workloads for home care workers.

Aronson and Neysmith[71, 72, 107] have shown how restructuring in health care has resulted in a diminished quality of work life for personal support workers. Aronson and Neysmith[71] describe the discrepancy between government policies which describe personal support workers' jobs in terms of the completion of instrumental tasks (such as housekeeping) and personal support workers' descriptions of their work as highly personal and caring. In an effort to "depersonalize" and cheapen the labour process, policies give little value (and compensation!) for the caring aspect of their work. Personal support workers in their study described the negative impacts of these cost cutting policies on their work: reductions in the length of time allotted to clients for visits; working split shifts; performing unpaid "on call" duties; speeding up in their work; pressures; tensions; anxiety; demoralization; dissatisfaction; frustration; feelings of guilt and reductions in support and supervision.[71, 73, 107]

In a previous study from the mid 1990s, Denton, Zeytinoglu & Davies[3] have shown that as a result of restructuring in Ontario, home care workers report organizational change, budget cuts, excessive workload, job insecurity, loss of organizational support, loss of peer support, and loss of time to provide emotional labouring or the 'caring' aspects of home care work. Analysis of the data showed that organizational change, fear of job loss, excessive work-load and lack of organizational and peer support all lead to stress and decreased job satisfaction.

Workplaces are changing as **non-standard jobs** are becoming more common.[33, 34] Despite the growth in non-standard work, research in this area is limited[78] especially on the effects of non-standard jobs on the occupational health and safety of workers.[115] The little research that does exist

however, suggests that contract workers may suffer proportionately more injuries and diseases.[11] Evidence also shows that it is women who are primarily employed in non-standard jobs.[33, 34, 116,117] Women are over represented in non-standard work such as part-time, temporary and home based work. And, these jobs are typically low waged, insecure, lack benefits and are unprotected by employment and health and safety legislation.[33, 34, 116-118]

3 b) Impact of Health Care Restructuring

Little published research exists on the impact of health care restructuring on home care agencies in Ontario since the introduction of 'managed competition' in 1997. Information has been published in newspaper articles, reports or briefs[26, 27, 120-128] or provided through anecdotal evidence to date. It has taken four years for the CCAC Boards to be established, competitions to be held and long-term contracts to be awarded to visiting nursing and homemaking organizations. Based on this information we have noted the following trends:

- an increase in job insecurity as agencies compete with each other for contracts for services,

- an intensification of home care work including:

- a reduction in the number of hours of services from a three to one hour duration, and thus a faster paced service,
- an increase in the number of clients serviced without a corresponding increase in agency budgets,
- an increase in the severity of health care problems due to the faster release of patients from hospitals; the growth in day surgeries and the trend to 'treat' more clients in their homes,
- the changing role of the personal support worker, taking on work formerly done by nurses such as bathing, hoya lifts, colostomies, condom catheters etc.,
- an intensification of emotional care associated with caring for difficult clients who suffer drug abuse, mental health problems, etc., in the community,
- increased workload as a result of the above,

- an increase in non standard work including the growth of:

- self-employment and working on a contract basis or partnerships by therapists,
- increased use of casual (part-time) nurses and personal support workers,
- the provision of day, evening and weekend services,
- relying more on the contingent workforce in the cost-cutting, competitive bidding process,

- changes in the organization of the delivery of home care including:

- a competitive environment,
- the reorganization of personal support workers into neighbourhood teams,
- the change to shorter visits which may not allow the same level of emotional care or physical care previously provided,
- no long-term commitment to employees in a sector where clients demand continuity and quality in service,
- high turnover rates and difficulties recruiting sufficient nurses and personal support workers,

- shortage of skilled home care workers,
- low pay and benefits in increasingly risky jobs, and
- no time to relax and recuperate from the physical and emotional demands of the job.

Based on the results of the literature review and our earlier research, we anticipated that many of these changes will impact the health and safety of home care workers. The research reported here and further analysis of the data will fill an important gap in the literature by addressing the effect of organizational change due to restructuring and privatization on the health and safety of home care workers in the New City of Hamilton.

3 c) Conceptual Model of Analyzing Organizational Change and Workplace Health

Based on the literature reviewed and our previous study, we developed a model for this study. The focus of analysis in our model is work-related health problems (workplace illnesses and injuries). We examine factors affecting those health problems, and the effects of these health problems on individuals and organizations.

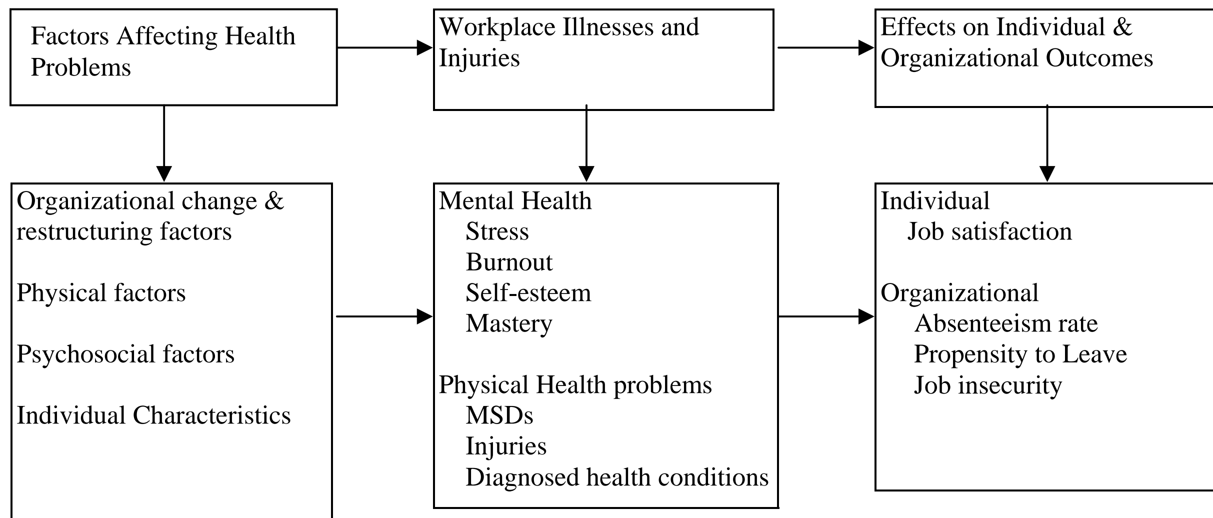


Figure 3 d) The Conceptual Model of Analyzing Organizational Change and Workplace Health

4. METHODOLOGY

4 a) Research Design

This research uses a mixed research design of qualitative and quantitative research methodology. We used key informant interviews, focus groups and a questionnaire to collect data. The triangulation of data in mixed research methodology gives us a more comprehensive picture of the phenomenon. For the qualitative part of the study, we asked open-ended questions in order to explore ideas and allow the interview and survey participants to elaborate on issues that were under discussion. The quantitative portions of this research included close-ended questions that also allowed for respondents to write additional comments if they so chose.

4 b) Data and Collection Process

In our earlier research project funded by the Social Sciences and Humanities Research Council and Health Canada (1995-1999), we worked in partnership with three non-profit community and social service agencies in Hamilton-Wentworth (the Victorian Order of Nurses, SEN Community Health Care, and VHA Health & Home Support Services), to study the relationship between work and health of home care workers. Since the date of this first study, the number of agencies with contracts to deliver home health care has expanded and there are now several for-profit and non-profit agencies who deliver community health care in the New City of Hamilton. Workers in several of these agencies have been unionized. This research addresses the work and health issues of employees in the original three agencies and also new entrants to the market in this region.

Between September 2000 and April 2001, we conducted 59 key informant interviews with the Chief Executive Officers, Directors, Managers, Administrators, Supervisors, Local Union Presidents or Chief Stewards, Management and Union Health and Safety Representatives, and Board Members of participating home care agencies in order to develop an understanding of the impact of health care restructuring on their agencies with respect to recent organizational changes and health and safety issues. The key informant interviews were followed with 29 focus groups, held between June and November 2001. In total, 171 employees from the participating agencies participated in the focus groups and provided input on the issues we had already discussed with the key informants. There were 5 focus groups held with nurses (RNs, RPNs), 4 focus groups with therapists (5 disciplines), 8 focus groups with home support workers, 7 with supervisors/coordinators, 3 with office staff, and 2 with case managers. We conducted focus groups for each occupation and separately for each agency. However, because the number of office staff members, for example, was so small and respondents could be easily identified, we conducted fewer focus groups with some occupations/agencies than had originally been planned.

The focus groups were followed by a mail-out questionnaire that was sent to all 1949 home care workers in the participating agencies. The questionnaires were sent between January and April 2002. A total of 1311 home care workers from eleven home care agencies in Hamilton-Wentworth responded to the survey, representing a response rate of 70%. The participating agencies were: VON, SEN Community Health Care, VHA Health and Home Support Service, Community Care Access Centre, Care Plus, Comcare Health Services, Community Rehab, Therapy Health Care, Therapy Specialties, Bayshore and St. Elizabeth Health Care. Table 1 indicates the number of respondents from each agency.

Table 1: Number of Participants per Agency

Agency	Number of respondents	**% of total**
VON	118	9.0
SEN Community Health Care	81	6.2
VHA	351	26.8
Community Care Access Centre	151	11.5
Care Plus	166	12.7
Comcare Health Services	155	11.8
Community Rehab	37	2.8
Therapy Health Care	24	1.8
Therapy Specialties	8	.6
Bayshore	133	10.1
St. Elizabeth Health Care	87	6.6
Total	1311	100

4 c) Instruments

For the qualitative part of the study, i.e. interviews and focus groups, a list of open-ended questions were developed and used as instruments. At the end of focus groups we distributed a short questionnaire. The interviews and focus groups results sections of this report are based on the questions asked in interviews and discussions in focus groups.

We developed the 2002 Health and Work Life Questionnaire for the quantitative part of the study. The survey results section of this report is based on the questionnaire and gives the questions used in this report. In summary, the 2002 Health and Work Life Questionnaire contains questions on mental health (self-rated health, subjective health, life stress, job stress, self-reported symptoms of stress, burnout, mastery, self-esteem), and physical health (diagnosed diseases, accidents and injuries, self-reported musculoskeletal injuries). It also contains many questions on the home care environment including questions on health care restructuring, opinions of the home care system, and changes in home care since 1997. Further questions address work life including job satisfaction, job security, workload, emotional labour, scheduling, office work, organizational support, working in clients' homes, and workplace hazards.

4 d) Measurements

4 d) 1. Interviews and Focus Groups

In interviews we asked questions about work at the participating organization, the impact of health care restructuring and managed competition on the organization since 1997, and changes in the work culture/environment of the organization. In addition, we inquired about human resource issues, the occupational health of workers, and we invited interview participants to make policy recommendations for both their particular organization and the home health care system in general. Very similar questions were asked in interviews with management and union representatives. However, we employed slightly different wording of questions as was appropriate (for example, we

modified questions including the term "your staff" to include the term "your members" for the union representatives).

In the focus groups we asked participants to discuss their work, the changes they have observed in the home care system and the impact of these changes on home care, their work, and service delivery over the past few years, their occupational health (both mental and physical components), and workplace health promotion. Finally, we invited the focus group participants to comment on changes they would make to the home care system and to their employing agency.

4 d) 2. Questionnaire

Information gathered through the key informant interviews and the focus groups, a review of current literature, and knowledge gained from our earlier study all informed the development of a self-completion questionnaire, the 2002 Health and Work Life Questionnaire, that was mailed to all employees of the participating home care agencies. To allow comparison to the 1996 findings (pre 'managed competition'), many of the same questions or measures were included in our new questionnaire.

In this questionnaire, we used several established and reliable measures of:

- mental health (i.e. mastery, self-esteem, burnout),
- measures of work related injuries, and
- measures of long-term health conditions diagnosed by a health professional (as used in the National Population Health Survey).

We also used measures that we developed in our 1996 study.[1-3, 6, 7, 81] These were:

- stress;
- job satisfaction, and
- self-reported musculoskeletal disorders (MSD). [The MSD scale is adapted from Kuorinka et al.[129]].

Furthermore, in this study we revised and expanded our previously developed measures of the following items:

- organizational change (organizational change, organizational support, concern with budget cuts, fear of job loss, workload, no time for client support, receive adequate information, control over work, fear of making a mistake, concern that important messages are not heard, peer support);
- structural working conditions (workload, fairly paid, good benefits, satisfied with hours, notified at last minute of schedule, time to plan for clients);
- emotional working conditions (emotional labour, client one-on-one, difficult clients, clients taking advantage, exposure to ethnic/racist comments, exposure to sexual comments);
- physical working conditions (safety hazards, job requires physical effort, job is repetitious, job involves travelling, no time to travel between clients, victims of crime on the job, injuries moving clients, physical office environment);
- work contract (full-time, part-time, casual, contract; job sharing);
- job insecurity (fear of job loss);
- work schedule (overtime, extended day, shift work, flexible schedule);
- individual characteristics (age, gender, years of schooling, living with children, marital

status, occupation, profession); and,

- personal characteristics (non-work related stress, dual workload, money problems, family problems).

While a few of these measures were based on single questions, the vast majority were multiple-item scales with high reliability scores.

4 e) Analysis of Data

4 e) 1. Qualitative data analysis

For the qualitative data, focus group discussions and key informant interviews were tape recorded and transcribed verbatim. We then read the transcribed data separately, and identified common themes relating to health concerns and working conditions. These themes represent expressions of concerns, positive and negative issues, and the views of the participants and interviewees on their work environment and changes within that. Following this independent first stage of analysis, we met to compare themes and developed a standardized coding scheme together. It is important to note that while the coding scheme was influenced by our expertise, previous research, and the literature on work and health, it was the verbatim comments of the interview and focus group participants that we heavily relied upon in the development of the coding scheme. Thus a coding scheme was not "imposed" on the data prior to reading the participants' comments. This technique for the development of codes in qualitative data is consistent with the guidelines suggested by Miles and Huberman[130], Krueger[131], and Morgan.[132]

The verbatim data was first coded by a research assistant and then double coded by a second research assistant. The research assistants met from time to time during this process to review their coding and to discuss any discrepancies in the codes. There was an internal consistency among coders and the intercoder reliability was high (> 80%). Then the codes were attached to the verbatim comments in QSR N5, a qualitative data analysis software program. If respondents expressed several ideas or themes in their discussions/interviews, each was coded separately. The data was analyzed using QSR N5 software in two ways. First, we counted the number of times each theme emerged in the respondents' answers to the open-ended questions. Second, all the verbatim responses related to each theme were printed and analyzed for content.

4 e) 2. Quantitative data analysis

For the quantitative data analysis, the survey data was first entered into an SPSS systems file. The data was then edited and frequencies or counts were produced for each variable. We constructed scales and tested each scale for reliability. The findings presented in this report are based on the counts for survey items. Further analysis is planned to identify the determinants of health for home care workers.

4 e) 3. Comparisons to the National Population Health Data

We compared our survey results to the 1998 National Population Health Data. We ask the question, 'Do the health problems experienced by home care workers in our agencies differ from those experienced by all employed Canadian women?' To answer this question, in our analysis we compare our findings with the Canadian National Population Health Survey (NPHS). Comparisons

are made between home care workers responding to our survey and all working women aged 20-64 in the NPHS on the incidence of long-term conditions diagnosed by a health care professional. The NPHS is a household survey designed to obtain information on the health of Canadians. The NPHS is longitudinal and designed to survey the same individuals every two years for up to two decades. The target population of the survey is household residents in all provinces and territories, excluding those living on Indian reserves, on Canadian Forces Bases, or in some remote areas. Most information was collected from a single household member. The final sample size was 26,430 households with a response rate of approximately 88% of households.[133]

There was also a short demographic questionnaire given to focus group participants. These questionnaire results were also analyzed using SPSS software.

5. KEY INFORMANT INTERVIEWS AND FOCUS GROUP DISCUSSION RESULTS

5 a) Key Informant Interviews Results

Fifty-nine key informant interviews were completed with CEOs, directors, managers, administrators, supervisors, health and safety representatives, board members and union representatives in the eleven participating agencies. The number of interviews varied per agency depending on the size and organization of the agency. Interviews ranged in time from 30 minutes to 180 minutes in length. Of the 59 people who were interviewed, 34 were from non-profit agencies and 25 were from for-profit agencies.

Many themes emerged from the key informant interviews. A summary of the most common themes to emerge from our analysis of the interview transcripts is provided below. These themes discussed in the following sections were mentioned by more than one quarter of all interviewees.

5 a) 1. Impact of health care restructuring and managed competition on clients and the delivery of services

In our interviews with the key informants, we first asked the question: how has health care restructuring (including the shift to managed competition) impacted on the home health care system, on clients and on the delivery of services?" The themes that emerged from this question in the interviews are presented in Table 2. Please note that we include the percentage of interviews in which the theme came up in the last column of the table.

The key informants reported to us that restructuring of the hospital sector has meant that clients are being released 'quicker and sicker' into the community. Further, there are many more day surgeries than in the past, and with the development of new 'technologies' many health care services (such as kidney dialysis, tube feeding, and cancer treatments) are now delivered in the home. The result of these developments is that clients served by home care agencies have higher levels of acuity, and also that home care agencies must provide service 24 hours a day, 7 days per week. Thus the demand for home care has increased.

> "…the issues we are dealing with are far more complex than we had in the past. And so, we are facing those issues without the surrounding support that you have in a hospital. In the hospital you call the head nurse, or you can call the doctor…"
>
> "now everybody's got all kinds of equipment in their home. And half these people should have never been sent home from the hospital in the first place. Or be on their own…"

However, we also learned from the key informants that home care budgets have not kept pace with the growth in the demand for home care. This has meant changes in the eligibility criteria for home care, such that the vast majority of care now provided in the home is personal and nursing care, with greater emphasis on acute home care and less emphasis on chronic care.

According to the interview participants, as a result of these trends there has been an intensification of work for home care workers. Home care work is now characterized by shorter visits and more visits per day. Visiting workers find that they are providing more complex care than in the past, their work day is more task oriented, and there is less time for the 'caring' or emotional

aspects of home care work. One key informant outlines some of the consequences of these changes in the context of nursing work:

> "…because of time constraints more so the nurse is focused on what it is they're sent in to do. And so she may not be looking [at the patient's care needs] as broadly as she was before, or she is maybe feeling like she's doing some of that [caring work] on her own time, and just worried about being on a treadmill, providing service on a treadmill. And I remember hearing my colleague on the health and safety committee saying she just wasn't sure how much longer she could do this, you know, be under this constant pressure of this time per visit…"

The key informants also pointed out that many visiting workers spend extra, unpaid time completing their work tasks and providing emotional support to clients. Workers from their agencies have noted a "downloading" of care under health care restructuring. Work once done by nurses in hospitals have been shifted to home care nurses; work once done by home care nurses or therapists has been shifted to personal support workers and work once done by personal support workers has been downloaded on the family members or is not being done at all. Importantly, home care workers claim that their workload has greatly increased as a result of health care restructuring and the shift to managed competition. "Heavy workload" was a common theme addressed by the key informants. One interviewee explained the drastic punitive measure she proposed to her employer in an attempt to cope with the workload:

> "I finally went to my [supervisor] and said, 'I never get to this [task], I can't do this [work], so would you suspend me for a week or two?' Suspending is good because I could rest, but they won't give me a suspension! When you feel that you can't do it, it's part of my job but I can't do it, I never get to it, it really upsets you…"

An additional theme that came up in interviews in response to our question about the impact of health care restructuring and managed competition is the loss of continuity of care. Some key informants expressed concerns with the quality of home care services. They noted a trend to "reduce holistic care", longer waiting lists for services, and a decrease in the continuity of care. This has had repercussions for both clients and service delivery, as is demonstrated by the following comments:

> "I think [restructuring and managed competition] are very stressful because the contracts that are awarded are awarded for only a [short period of time]. And it's very difficult to work in an area for 3 years and learn to know where people live, and get to know your clients, and then all of a sudden, you lose the area and you have to go somewhere else…"

> "… the RFP process does not lend itself to proper care for the patients because you could win one for two years, three years, and then right after that you get tossed out and somebody else gets picked. So a) the people receiving care are being flipped in terms of caregivers every so often which is not I understand from the medical literature and research that has been done, the continuum of care with caregivers is an important aspect of the quality of care that is given. It also doesn't lend itself to the organization's investing any money in training or initiatives of partnerships, joint ventures with other organizations to provide, produce special services or innovative programs. Because no one's going to invest money with the sore hanging over your head that in two years you could be gone anyway."

Furthermore, the key informants pointed out that inconsistencies in the volume of work as a result of restructuring and managed competition affect their workplaces and employment at their agencies:

> "You bid for an amount of money. When they bid, they're assuming the average client will pay x amount of time. And therefore you have to run on a time constraint. If you're not on their time then your employer's losing money. Your employer loses money, you don't make money, and there'll be no job…"

5 a) 2. Impact of health care restructuring and managed competition on their organization and employees

Key informants also told us about the impact of health care restructuring and managed competition on their organizations and employees (See Table 3). The themes that emerged from those interviews are that the organizations are becoming more business oriented with emphasis on making strategic business decisions and plans; there have been changes on the organizational design/structure, changes on the work design and process, changes on the work and organizational culture, and changes to the pay and benefits structure.

Interviewees told us that they had to work more like a business first, and a caring organization second. Making business plans for the viability of their organizations was a priority. Also, accreditation was an important goal for many, and risk management in community was becoming extremely important. Furthermore, the key informants discussed the adjustments their organizations were trying to make in response to the decision made by the government to divest therapy services.

In terms of organizational design and structure, the key informants explained that the organizations were creating a design that focused on efficiency and productivity. There was more emphasis on quality control, increased accountability and emphases on continuous improvement at home care agencies. Process changes and total quality management approaches had been adopted and were considered the key to surviving managed competition and healthcare restructuring. In addition, key informants noted that work design and work processes were changed due to the extensive use of technology. They said that not only computers and information technology were being used, but also most communication was now achieved through new technology of voice mail, cell phone, e-mail and faxes. For example, work schedules were being faxed to homes of visiting staff and reports were being faxed back to the office by the visiting staff. Many workers had home offices. They interviewees said:

> "We communicate through voice mail, e-mail, 'hot notes' on clients. All employees who service particular clients can read or leave information about the client in the 'hot notes'. It keeps people better informed about client issues. We are constantly looking at risk management issues, CQI (Continuous Quality Improvement) teams."

> "We just started a beautiful CQI team. We call it a Continuous Quality Improvement team, so we had our people from human resources, we had some people from nursing… and we did exactly that. What are the problems in human resources? Why aren't we attracting staff? Why are some staff leaving? …We have our human resource department right now looking at ways to collaborate and partner with Brock University."

In our interviews, the key informants also mentioned how the work flow has changed; in particular, coordination, supervisory and support staff roles were different as a result of health care restructuring and managed competition. Workers are now expected to multi-task and for some this enriched their jobs. New uses of technology have also changed the flow of communication and information at agencies. Some interviewees perceived this change as a cost-cutting measure that also increases efficiency. However, others said that the use of technology has increased the isolation of the community workers and made it impossible to share information on an informal basis.

Key informants also discussed changes to work schedules as a result of health care restructuring and managed competition. There was a shift to even more casual, part-time jobs in the home care sector. This was particularly the case for personal support workers and visiting nurses, but some office staff also found that the only jobs available were casual and/or part-time. Referring to part-time casual work, one interviewee made the following observation:

> "As a branch manager, I want the staff's dedication and their loyalty, but yet I am not in a position to guarantee much in return, for example in terms of job stability. …What everyone wants is stability but there are no guarantees with the RFP process. Employees mostly work part-time."

Furthermore, as a result of restructuring the agencies were not able to guarantee the long-term viability of their agencies and therefore continued employment to their staff. Key informants discussed this theme repeatedly in the interviews:

> "We have lost some patients that we have looked after for 10 years, and then all of a sudden, competition from another agency, they win the competition, they now take it over, we've lost patients, we've lost contracts, therefore causing great stress to both the nurses, having to change areas, having to change clients, having to change the type of care they're doing…"

> "It was true before that agencies could not guarantee hours to workers. That has always been the case but on top of that now not only can we not guarantee hours we cannot even guarantee that we are going to be in business in five years."

Therapists have had perhaps the most dramatic change in their work environment with the switch to managed competition in 1997. Previous to managed competition, therapists worked as full-time salaried employees for the non-profit Home Care Program (HCP). With the collapse of the HCP and change to the CCAC model, the therapists had to find new employment either as self-employed or as contract workers with for profit agencies. According to the interviewees, this was a challenge for many therapists. One said that working without workers compensation coverage was very threatening, and she indicated that she was worried about hurting herself on the job and not being able to work, thereby losing all of her income.

Under the new system of managed competition, agencies compete for contracts to provide services through a request for proposal (RFP) process. The RFP involves agencies submitting proposals that detail how and for what cost they will deliver the care in a specified geographic area. Many interviewees mentioned difficulties mastering the RFP process and some agency key informants complained about losing contracts in areas where they had a long history of providing home care services. They spoke about a decrease in co-operation between agencies due to the

competition between them for service contracts. There was an expansion of the number of agencies serving the Hamilton-Wentworth area after the introduction of managed competition and some agencies had taken the opportunity to expand their service areas into other CCACs. Key informants mentioned some positive outcomes of the managed competition system including the shift to business focus for non-profit agencies, increased efficiency, formalized standards and greater accountability.

One result of health care restructuring was the introduction of unions to the home care sector. The CCAC and three of the non-profit agencies had been unionized and together the managers and workers are adjusting to a union environment including strikes at the CCAC and the VON during the period of our study. Two key informants explained the history, development, and impact of unionization:

> "We were unionized after the RFP process started… And I think a large part of that was a reaction to the process. [The workers] saw, you know, a threat to job security and the increasing threat that was being put on the organizations. Because now in an RFP you've got to deliver so much care at such a price. You're gonna get a certain price. Now all of a sudden there's more emphasis on, you know, cost control and how many clients can you see in a day. And so I think all those things were natural attractions for unionization."

> "We already had, before we became unionized, contracts that set hourly rates with CCACs. Along come the unions, they negotiate a contract, their rates go up, their benefits packages go up because they're going to get something better because they've negotiated a contract."

5 a) 3. Health consequences of health care restructuring and managed competition

The key informants were asked about the health issues in their organizations. Most spoke of work-related stress as a major health concern in their organization. As shown in Table 4, the interviewees discussed a number of restructuring related factors creating stress among their workforce.

Managers mentioned that system restructuring and, in particular, the RFP process, has had a major impact on themselves and their workers. They made the following comments:

> "I know that next year I have 3 RFPs and there's 3 months for each of those RFPs, so it is an extremely stressful time…" "I see the stress level inside this building itself, with our clerical staff and so on, it goes up and it goes down. And it goes up and down with what is happening with our contracts with the CCAC"

> "I think that it [managed competition] has a lot of stress on our organization. Stress would be the competitive rates, the competitive way of applying for it. I guess there's stress for us and stress for the community workers, being able to manage and keep up with the RFPs."

> "It [managed competition] creates stress in our own office environment. Because we do [RFPs] ourselves inside…so it's a very high stress situation for about 6 weeks… I think the stress level goes up and down, like it fluctuates. When you're going into an RFP, you have a stress level pretty high… And when you've been granted a percentage of an RFP the stress

level goes up again which you'd think it would come down, but it goes up again because you have to fulfill those staffing and those requirements of your contract…."

According to the key informants, the RFP process was creating the fear of job loss and stress among staff:

"There is this constant fear that we are going to lose the contract…"

"I think it's [managed competition] been unsettling for the staff in general. We don't know what the future holds…I think it's a time of uncertainty, I think it's increased the stress on staff…"

In terms of staff shortages causing stress, a supervisor said:

" There is shortage of workers in the community, so it is always stressful trying to satisfy all the clients."

For scheduling issues, therapists noted that in order to get the contract from the CCAC, they had to note everything which resulted in higher paperwork, and they 'had to be available 24-7.'

Another said: "We don't have guaranteed work hours anymore."

Stress was so intensive for some home care workers that the key informants spoke of being "burnt out" on the job. They said:

"Health issues we have are stress and coping, and burnout. The causes would be: not being valued, poor morale and the working conditions of increasing accountability and responsibility."

In terms of physical health problems, the key informants mentioned that some workers were physically tired or exhausted by the end of the day. There was a concern about musculoskeletal problems for the staff at agencies. We asked key informants for their opinions on the main causes of these health care problems, and they identified system restructuring, client change factors (acuity, length of stay, complexity of care), staff shortages, work design, physical effort (lifts, moving clients) and workload as sources of mental and physical health problems. One said probable cause of these changes is "changes in the health care system."

Another key informant explained the reasons for the high rate of musculoskeletal disorders she was seeing among staff this way:

"The physical nature of their work and the increase in the complexity of care including more transfers results in more strains and sprains to the back, knees and shoulders."

"Shorter visits, hurrying, doing things like mechanical lifts with only 1 staff is risk to client as well as staff. Heavy care clients are cared for in home. This is nice for client, is cost effective, but what is the impact on employee? We need to balance safety of care providers against what is nice for the client."

5 a) 4. Effects of restructuring, managed competition and work-related health problems on job satisfaction

Although work-related stress was high, the key informants told us that most home care workers were satisfied with their jobs. As presented in Table 5, interviewees said that workers were satisfied with working with clients one-on-one, satisfied with relationships with clients, the autonomy they had and the flexibility the job provided. They were dissatisfied with work scheduling (of casual, part-time schedules, irregular work schedules) and dissatisfied with pay. Key informants from some agencies felt that job satisfaction and morale was high in their agencies. Others felt that job satisfaction and morale was low in their agencies due to the impact of managed competition on their agency.

In response to our question, in your opinion, are home care employees satisfied with their jobs? Why is that? They said:

"Nurses no, we have lost so many. Many are still in the community, they have just gone to other nursing agencies. We have done satisfaction surveys with our home makers and for the most part they are satisfied. They have issues with isolation, low wages but many enjoy their jobs."

"All of our staff has been impacted [by the RFP process]. Some of our staff were employees of CCACs for 20 years. So, change has really impacted on some of them. And some of them have done really well, and some of them just go with it. And they're happy, with their jobs and that, but it's really hard, because from one year to the next year you don't know for sure, like if you RFPed into Hamilton and you know that you're working there, and then the next year you're RFPing some place else, you don't know what it is until 6 months down the road."

5 a) 5. Recruitment, retention and turnover issues as a result of restructuring and managed competition

Human resource issues were a major concern for key informants. Issues of recruitment and retention were a common complaint in the interviews. The participants explained that agencies were experiencing high turnover rates and were also having difficulty recruiting nurses and personal support workers. Referring to the frequent work situation where the agency is short of staff, a key informant explained the predicament for workers:

"…And as a result when you are short of staff it does impact because you get the voice mail from the office saying please, please can somebody pick up these two new admissions. So

> you can only listen for so long before you say, ok fine I'll take them whereas you should be saying no, I've got my full load, I can't do anymore."

Moreover, restructuring and managed competition have created a situation in which workers feel pressure to work more hours and to work when they are not well:

> "For those who want to work part-time, it's tough as we are calling them constantly to work more. They are feeling the pressure to work more because of staff shortage…"

> "Another issue is when people are sick, it's feeling guilty when they are sick, saying 'I know I shouldn't be working, but I can't [not work]', knowing that your co-workers are now doing overtime…."

The key informants had also observed that nurses and personal support workers were attracted to jobs in hospitals and nursing homes where the wage rates were much higher for comparable jobs. Thus, the issue of 'wage parity' was a major concern.

> "The biggest one I think is the wage disparity. That's a huge issue because you lose nurses to the hospital sector. In the past there was this wage gap but it was made up for by the fact that a home care nurse didn't work shifts, didn't work weekends, and didn't see the acuity that the nurses in the hospital saw. So that would seem to balance the wage disparity. But now, those have all disappeared. We have shift care nurses, we do work shifts, we do have to cover weekends, and you're seeing the same illness level in people. So now they're saying, if I'm gonna see all that, I may as well go to the hospital and make, you know, five bucks more an hour than I'm making here."

5 a) 6. Health Promotion

Key informants were then asked, "What is your organization doing to promote workplace health?" Activities mentioned in the interviews included health and safety committees, training sessions, employee assistance programs, creating a supportive environment and employee recognition or events. (See Table 6)

5 a) 7. Recommendations for the system and organizational changes

Finally, the interviews ended with the question, "If you could make changes to the home health care system what policy recommendations would you suggest?" Themes that came up in response to this question are presented in Table 7. Key informants concur that funding and resources need to be increased and that wage parity with the hospitals and institutions is necessary to address recruitment and retention issues.

> "Equal compensation or better [than hospital workers] for workers in the community. Funding taken from hospital sector should be redirected to the community."

However, the key informants gave us mixed messages on managed competition. Many want to abandon managed competition, while others want to make changes to the system including revising the RFP process to include longer contracts and recognizing history in a service area.

> "I know years ago, the model that started this was the MSA, where we all became government employees. If we're looking at a managed home care, or health care, that may be the way to go. The RFP process needs to be thrown out, it doesn't work, it just doesn't. Cheaper health care doesn't."

> "The RFP process, the whole process needs to be looked at."

Also suggested by the key informants was a standardization of the RFP process across the CCACs.

> "Speaking for Ontario, there is a lot of difference in tendering process,…there is not a standard set of tendering of the Community Care Access Centres, what one wants the other does not. I think there needs to be more of a coming together of the process."

5 b) Focus Group Results

5 b) 1. Demographic characteristics of respondents

Twenty-nine focus groups were completed with non-managerial staff from the eleven agencies. Again, the number of focus groups varied depending on the size and number of occupational groups employed, but in total we conducted 29 focus groups [5 focus groups with nurses, 4 with therapists (5 disciplines), 8 with personal support workers, 7 with supervisors and co-ordinators, 3 with office staff, and 2 with case managers]. Table 8 displays demographic characteristics of the focus group participants. (Survey respondent characteristics are provided in the third column for comparison purposes. As presented in the table, the focus group respondents reflect the demographic characteristics of the respondents in the survey.)

5 b) 2. Common themes emerging from focus groups

There were many themes that emerged from the focus group transcription data. Below, we provide a summary of the most common themes to emerge from our analysis of the transcripts. These themes were discussed in more than one-quarter of all focus groups.

5 b) 2.1. Positive aspects of their jobs

Focus group participants were asked about what they liked and disliked about their jobs. Positive aspects of the job included: flexibility, autonomy, the challenging nature of the work, working one-on-one with clients, promoting the independence of clients, their relationships with clients, and the sense of "doing good" or altruism that the job brings (See Table 9). Home care workers made the following comments about the positive aspects of their jobs:

> "For myself it's the flexibility. I can sort of make my own hours. So it works out great for me, I can put my daughter on the school bus and then go to work and be home in time to take her off, and during the day I can take as many schools or not so many as I want. So it's really the flexibility, it's a very positive aspect."

Discussing the autonomy that the job entails, the challenging nature of the work, and the satisfaction that working one-on-one bring to them, focus group participants said,

"I like my independence. I like being able to plan my day as I go and being able to take a break, possibly, in the middle of the day, just basically the independence, getting to start roughly around 8, but if I'm 10, 15 minutes running behind it's okay, I'll just work 10, 15 minutes later in the afternoon, so I like the freedom that way."

"I love one-on-one. I love just focusing on one person and you have time in between the person to think what you did, and maybe what you should do, and you know [this is] Cadillac care, you actually give them 100% when you're there."

They liked working with the clients and promoting their independence by assisting them living in their familiar environment of their own home. They said,

"As far as care in the home, you get more satisfaction knowing that you're helping somebody in their home, because they are much happier in their home, particularly if they are starting to get [old and] confused."

"… it's the patient-contact and the interaction between patients and families that make it all worthwhile, certainly not the stress and everything that keeps us here, it's the patient contact that keeps us here and knowing that you make a difference, so three out of four of us are palliative care nurses. You probably give some kind of care as well, so it's knowing that what you do is worthwhile and that makes a difference. That's really the upside of it."

5 b) 2.2 Negative aspects of their jobs

The aspects of the job that the focus group participants did not like included: dealing with difficult clients, the lack of respect paid to them by some clients and from the CCAC, the shortage of home care workers, issues pertaining to travel, the scheduling of home care work, and unsafe working conditions in clients' homes (See Table 10).

Many focus group participants from the visiting agencies felt that the CCAC case managers did not provide adequate case management of client care, but rather attempted to supervise the care provided by the home care workers in other agencies. Micromanagement of home care work by the CCAC came up in 6 focus groups (1 with nurses, 2 with therapists, and 2 with supervisors). This item is not contained in Table 9 because only 21% of the focus group participants discussed it. However, it is important to note that it was those in decision-making positions in the agencies who questioned the CCAC case managers' micro management of client care. This was perceived by these individuals as professional discourtesy on the part of the CCAC. One focus group participant made this point quite strongly:

"I'm an R.N., I don't want to go see someone twice a day unless I have to, why should I have to explain every single little [task I am doing], but they [CCAC Case Managers] really interrogate you and that's insulting, it's very insulting when they interrogate you and it's just like, are you telling me that I am not professional enough to feel what this person needs?"

In addition, the shortage of home care workers and the impact of this shortage on home care work was a frequent topic of discussion in the focus groups. Many participants reported that they were asked to take on an additional client at the end of the day or to work during their days off in

order to cover the shortage of workers at their respective agencies. Also, due to the intensification of work, many focus groups members felt that they did not have enough time to complete their jobs. As a result, many were providing "unpaid care" or taking their paper work home to complete. For example, a nurse in one focus group noted that the additional time she spent planning the next work day and contacting people concerning work is not paid time:

> "When you go home, you're thinking your next day, patients with you in your mind, what you gotta do, planning your day, I'm on the phone for at least two hours at night."

The additional (unpaid) work that is a vital part of providing home care was expressed by another participant:

> "…and I was told that all I have to do is make a couple of phone calls, but I don't get paid for doing that."

Issues pertaining to travel were another area that came up in the focus groups during discussion of aspects of the job that workers disliked. The participants noted that travelling in bad weather, not being provided enough time to get to the next client, and the lack of travel cost coverage by some agencies were all matters of concern. In particular, home care workers expressed that travel time is not included in the hours that they get paid, which presents difficulties as these individuals have to make numerous trips each day in order to visit their different clients:

> "They took travel time away. We used to get paid for travel time."

For co-ordinators, work scheduling issues were a "nightmare". Without enough home care workers (due to labour shortages) and without the ability to predict the volume of care, it was a constant struggle for the co-ordinators who participated in the focus groups to arrange the provision of services to clients. Furthermore, the scheduling challenges greatly increase the volume of work for these individuals. One co-ordinator commented on this work intensification:

> "I think that volume, the volume of work that we all have to produce in one day is horrendous… and the volume of things that you do that are not in your job description… I mean that might make up about 30, 40% of your workload."

Home care workers expressed dissatisfaction with some clients' high expectations of service provision, and also noted that working with difficult clients is an aspect of their job that they dislike:

> "So when [clients] get all these different people going in doing the same jobs but in a different way or a different routine, they don't trust them… And like they're angry because we sent strangers in. I mean it's not that the other people taking our place aren't qualified because they are. But they don't have that one-on-one continuity. And that is important. Both for the client and for the worker. Because as the regular going in, if I take three or four days off and I go back, I'm the one taking the abuse. They won't say anything to [other worker], [other worker] is great, but when I go in it's – 'Where have you been?' and 'She didn't do this, she did this differently.' And although it's petty little things and, you know, it's not that [other worker's] not doing her job, it's just that she's not doing it exactly the way that I am. Cause we're not cloned."

> "Like some [clients], if you tell them like, you know – 'Don't smoke while I'm in here' – they will just tell you like, you know – 'well, it's my home, I have the right to do what I want in my home' – so. You just have to go along with them, you can't argue with a client. We were told we weren't supposed to argue with our clients."

Lastly, the focus group participants discussed unsafe working conditions in clients' homes as a negative aspect of their jobs. The unsafe working conditions that were especially of concern to visiting staff include safety hazards such as unclean homes, needle stick injuries, exposure to infectious diseases, and exposure to "super bugs". The physical requirements of the job including repetitive motions and the lifting of clients were also mentioned as negative aspects of the job.

5 b) 2.3. What they liked and disliked about their agencies

In addition to questions about what the focus group participants liked and disliked about their jobs, we also asked participants questions about what they liked and disliked about their agencies. The most common positive factors mentioned were organizational support, peer support and good communication. The negative factors included: lack of organizational support, poor pay, inadequate benefits, scheduling issues, poor communication, pressures "to take more clients" or work when sick, and various agency policies and procedures (See Table 11).

5 b) 2.4. Impact of health care restructuring and managed competition on the system, their jobs and clients

A third area of inquiry in the focus groups related to health care restructuring. In a similar fashion to the guided discussion in the key informant interviews, we asked focus group participants to describe the impact of health care restructuring and managed competition on the home care system, on their job, and on clients.

The workers mentioned how health care restructuring and managed competition has resulted in financial cutbacks. For example meetings were not mandatory for visiting staff anymore because the employing organization did not have funds to cover them. One said:

> "No, they're [staff meetings] not mandatory anymore because we used to get paid for them and that's why it was mandatory."

Not being able to meet with their co-workers and supervisors face-to-face resulted in communication problems: workers did not know much of what their managers and supervisors were involved in what was expected of them, information was not being shared and informal learning that can take place in these meetings was not taking place. Workers were feeling isolated.

Resulting from the cutbacks were personal income loss and different pay for the same work depending on the agency workers are employed in. The point about personal income loss was expressed by a nurse participant, who commented that workers are no longer able to maintain the lifestyle and living standards that they previously enjoyed prior to the cutbacks:

> "…and when all the cutbacks came in it became very difficult to do the same thing and still keep yourself financially okay."

Also mentioned was the trend towards downloading of care and a reduction in the quality of home care services. Participants spoke of the intensification of their work, the reduction in the length of visits and the corresponding increase in visits per day, and the increase in their workloads resulting from the lack of resources to the home care sector:

> "I am given only an hour to do palliative care but built into that is 15 minutes of driving to the next client and the paper work (filling of charts) I have to do. You can't give palliative care in 45 minutes… I run in the door and do what I have to do and run out the door and I'm on the phone in the car while I'm driving, telling the next person I'm on my way because we have to call them before we get there."

One participant remarked, "Some days the workload is far too many", and another added, "We were told you'll have 10 clients a day. Right now we're working with 16 or 17 clients."

The introduction of managed competition in the home care sector has also impacted participants' jobs in important ways. Many home care workers spoke of their difficulties mastering the Request For Proposal (RFP) process and the insecurity of their employment due to possible loss of contract. Several nurses and therapists commented on these challenges:

> "…One of the big stretchers in my mind is, will I have this job which I have been enjoying for the past 21 years, will I continue to have this job and the only reason I'm afraid I won't have it is because of the RFP process, because if they don't get the contract."

> "Compared to where we were in the mid-90s,… we are basically an itinerary work force….I had a pension to look forward to. …Now every three, four years, it's up for grabs, and the whole community is up for grabs. And that is a very unsettling way to live in."

> "We don't have job security either. We don't know, in the next RFP, if we're going to get the contract, how much of the contract are we going to get? Are there going to be layoffs? Even people, people who have 10, 12 years of experience with the last RFP were told that they might get laid off because there just wouldn't be the case load or the patient load to carry that many nurses. It's terrible."

The focus group participants also voiced concern about changes in support or relations with other home care agencies. Table 12 provides more details about the issues discussed by participants.

With respect to clients, the focus group participants felt that health care restructuring has increased client acuity, decreased continuity of care and that many clients were "falling through the cracks" because of lack of resources and changes in eligibility criteria. Supervisors discussed the early discharge from hospital and resulting care issues for workers in a focus group:

> "Yes, the clients are going home before they're really recovered. Whether it's surgery or medical issue, or a new baby - you have it, you're done and gone."

> "So our nurses are seeing more acute, more high risk and there's training involved with that too. So their anxiety levels will go up for that. Our nurses are fairly skilled but something as

simple as a Caesarean section you know… might have problems and all the other stuff you know."

"Yeah I think, [scheduling clerk] was telling me about receiving on a Friday afternoon at 4 o'clock there were three women who had mastectomies that morning, and they were being released. That's really frightening you're having to deal with that."

5 b) 2.5. Health consequences of health care restructuring and managed competition

Mental and physical health problems were other themes that emerged from the focus groups in response to questions about the impact of health care restructuring and managed competition (See Table 13). In terms of their mental health, the participants reported that health care restructuring and the move to managed competition had increased their stress, their frustration level, and had resulted in both mental exhaustion and tiredness. Stress was so intensive for some home care workers that they spoke of being "burnt out" on the job. A home support worker explained her burnout this way:

"You end up being such a people pleaser that you want to make sure everyone's satisfied and if you do that, by the end of the day you're just… you burn out."

Likewise, the following exchange between several nurses from a focus group further elaborates on the link between stress and health care restructuring:

"We lose contracts and then we have to downsize"
"And you know what? Its very stressful."
"…[There are] nomadic nurses, they go where the contracts are."
"It's ridiculous, yeah."
"Which is not good for the nurses either because they don't have any kind of job stability."

In order to explain her mental exhaustion, a nurse commented:

"You're trying to remember, this person needs this and that person needs this."

In terms of their physical health consequences from these organizational changes, many participants expressed concerns with musculoskeletal disorders, accidents and injuries:

"I'm here with a cane today, and as my doctor has said to me, my job has definitely influenced my knees. Bending down, doing dressings, getting in and out of the blinking car. So now I have, I'm looking forward to a knee replacement."

"It's nursing, a lot of people end up with bad backs, bad knees, bad hips."

One of the office staff described the physical health consequences she has seen in her workplace:

"I think amongst my colleagues a lot of them have complained of muscle strain. You know, back ache, pain in their shoulders, neck pain."

A nurse discussed the risk of physical injury from accidents in a focus group:

"We've been fortunate. We've never had anybody killed in this agency but we've had a lot of people in [car] accidents."

Physical exhaustion also came up in discussion with home care workers:

"Well I can use last week as an example where I told you I worked far more visits than I ought to have. Thank goodness this week's better 'cause I don't think I would have survived two of them! I literally can tell you that last Tuesday night, I went home, literally collapsed in a chair, and was so exhausted I could not move. And I lay there for about ½ an hour before I finally got up the courage to get my coat off and to get out of the chair. My phone rang and it was a friend of mine who called and I said, 'Look, I'm sorry, I can't talk to you. I'm too tired.' And that was the truth."

5 b) 2.6. Job satisfaction and morale issues as a result of restructuring

Health care restructuring and managed competition has also affected morale and job satisfaction among the focus group participants. Workers from some agencies appeared to have high morale and job satisfaction, while others expressed low morale and job dissatisfaction. Job satisfaction and high morale was mentioned in 23 focus groups (79%) and job dissatisfaction was mentioned in 20 focus groups (69%). It seems that for some workers, health care restructuring and managed competition have decreased their extrinsic (relating to financial/ monetary) job satisfaction. Intrinsic job satisfaction however, is high as discussed in Table 8 (relating to positive aspects of the job):

"I wouldn't trade in my old folks. I love them… I do enjoy my job. Right now, yes, I'm a bit stressed and harassed, because we are working too hard. We have far bigger client loads than what, speaking for myself anyway, than what I can handle."

The personal income loss is linked to job dissatisfaction by a nurse:

"Nobody's satisfied with what's going on in the community right now. There's a lot of problems. There is a lot of wage inequity stuff that needs to be rectified."

5 b) 2.7. Health Promotion

A further question asked in the focus groups pertained to the promotion of health within agencies. With the exception of organizational support, most focus group participants did not mention any explicit health promotion activities organized by their employing agency. However, the participants did discuss health and safety activities that organizations should be doing anyway (such as having a health and safety committee, and training for safety at work) as examples of health promotion. This suggests that there is a lack of understanding of the importance of health promotion in these workplaces. Table 14 contains themes that emerged from discussions of health promotion.

5 b) 2. 8. Changes recommended to health care system and agencies

Finally, we asked focus group participants to recommend changes to the health care system and to their agencies. Most participants recognized the need to increase funding to the home care

sector. They suggested that agencies need to increase the number of their staff and increase staff compensation. Participants were much more vocal about the changes they would recommend to the health care system. First, they suggested the establishment of wage parity with hospitals and long-term care institutions.

> "Community nursing or community agencies are grossly underpaid compared to hospitals. Then, it's hard for nurses and difficult for us to recruit nurses to this deal."

Second, many suggested changes to the system of managed competition. Some would abandon it altogether, while others would revise the RFP process by standardizing it across the province, recognizing history, and fixing the wage rates so that agencies compete on quality and not on price of service. A case manager comments on this:

> "It bothers me a lot that the RFP process does not take past performance into consideration. So what it comes down to in my opinion is pretty well, the one who can submit the best written proposal gets it. There is nothing in [the RFP process] about the history of, the quality of the organization. Provincially, there is no standardization."

In another focus group, one nurse with 30 years of experience remarked on the difficulty of mastering the RFP process:

> "I think the RFP is detrimental, very detrimental to the patient, very detrimental to the nurse. I have been [at this agency] for 21 years, I don't know if we'll have a contract here."

Further suggestions included providing a greater voice to service providers; more attention and resources to education and training; and better evaluation of clients needs. The recommended changes that emerged as themes in the focus groups are presented in Table 15. For example, the following comment from a home support worker about their low level of compensation, in particular the lack of benefits as a cost-cutting measure for their employers to get CCAC contracts illustrates the frustration felt by some focus group participants about conditions in their work:

> "I'm not paid for that [travel]. We're paid for our work and that's it. We supply our own uniforms. We supply our own shoes. We have to carry shoes with us. We supply our gloves."

5c) KEY INFORMANT INTERVIEWS AND FOCUS GROUP RESULTS TABLES

Table 2: Interview Results: Impact of Health Care Restructuring and Managed Coopetition on Clients and the Delivery of Services

Item mentioned in interviews	No. of interviews mentioned	% of interviews
Client Impacts		
Higher client acuity, shorter length of hospital stay, increased complexity of care, higher client satisfaction	49	84
Increased public expectations/ awareness for client care	29	50
Service Delivery Impacts		
Heavier workload or intensification of work	34	59
Reduced length of home care visits/ more client visits per day	25	43
Downloading of work	28	48
Lack of resources (insufficient funding, pressure to discharge from home care program, delays in obtaining service for clients, less money available for service delivery, lack of long-term care beds, capping services, inadequate funding to support base functions such as education, supervision, training).	46	79
Loss of focus (loss of preventive care function, holistic approach, shift to sub-acute system)	29	50
Loss of continuity of care	31	53
Inconsistencies in the volumes of work	24	41

N= 58 Key Informant Interviews

(Note: There were 59 interviews with one interview conducted with two individuals. That is considered as one document in this data.)

Table 3: Interview Results: Impact of Health Care Restructuring and Managed Competition on the Organization and Employees

Item mentioned in interviews	No. of interviews mentioned	% of interviews
Effect on Organizational Design/Structure		
Creating a mechanistic design for efficiency and productivity	27	47
Reorganization of service delivery models	15	29
Effect on Work Design and Work Processes		
More emphasis on quality control, increased accountability, emphasis on Continuous Improvement Process or TQM models	31	53
Work design and work processes changed: more technology is used (computers, information technology, distance communication, home offices, technological equipment in the home)	29	50
Work design and work processes changed: work flow changed (coordination, supervisory and support staff functions changed, job is enlarged, job is enriched, communication/information flow changed)	31	53
Work schedules changed (shift to casual, part-time, contract work schedules)	21	36
Effect on Work & Organizational Culture		
Workplace became more outcome oriented, with business mentality (focus is on productivity, transformation from care giving service to business delivery approach, focus on risk management in community)	39	67
Mastering the RFP process	32	55
More peer (co-worker) support	23	40
More organizational support	21	36
Changes in support/relationships with other agencies	30	52
Unionized environment (unions came in and new workplace atmosphere)	20	35
Changes to Wages and Benefits		
Wages increased (due to unionization and pay equity settlements)	37	64
Better or more benefits (due to unionization)	22	38

N=58 Key Informant Interviews

Table 4: Interview Results: Factors Causing Stress

Item mentioned in interviews	No. of interviews mentioned	% of interviews
System restructuring causing stress among workers	25	43
Organizational change	19	33
Fear of job loss	14	24
Client change factors (acuity, length of stay, complexity of care)	16	28
Staff Shortages	16	28
Scheduling issues	27	47

N=58 Key Informant Interviews

Table 5: Interview Results: Job Satisfaction or High Morale or Job Dissatisfaction/ Low Morale as a Result of Health Care Restructuring and Managed Competition

Item mentioned in interviews	No. of interviews mentioned	% of interviews
Satisfied with relationships with clients	18	31
Satisfied with the autonomy	15	26
Satisfied with the flexibility	16	28
Satisfied with working with clients one-on-one	34	59
Dissatisfied with work scheduling	15	26
Dissatisfied with pay	20	35

N=58 Key Informant Interviews

Table 6: Interview Results: Health Promotion Activities

Item mentioned in interviews	No. of interviews mentioned	% of interviews
Health and Safety committee	36	62
In-service training	39	67
Information pamphlets	15	26
Employee Assistance Plan	15	26
On-site training	22	38
Stress leaves available	11	19
Provides equipment such as gloves or masks	11	19
Employee recognition or events	24	41
Provides supportive environment	37	64

N=58 Key Informant Interviews

Table 7: Interview Results: Recommendations for System/Organizational Changes

Item mentioned in interviews	No. of interviews mentioned	% of interviews
Wage parity with hospitals/ long-term care institutions	14	24
Revise RFP process	30	52
Eliminate the RFP process	11	19
Return to holistic model of care	14	24
Integrated/continuum of care	32	55
Increase funding	44	76
Increase number of staff	15	26
Increase staff compensation	24	41
Provide educational support/in-services	14	24
Provide more organizational support	33	57
Improved communication	20	35
Employee participation/involvement/recognition	24	41

N=58 Key Informant Interviews

Table 8: Demographic Characteristics of Focus Groups

Characteristic	Focus Groups	Survey
Gender (% Female)	96%	94%
Age [mean (std.dev.)]	43 (10)	45 (10)
Marital status (married/common law)	65%	66%
Have dependent children	60%	63%
Immigrant	25%	35%
Member of a visible minority	n/a	11%
Member of an ethnic group	n/a	30%
Those contributing 50% or more of the family income	n/a	55%
	N=	N=1311

Table 9: Focus Groups: Positive Aspects of the Job

Item mentioned in focus groups	Number of focus groups mentioned	% of focus groups
Flexibility	17	59
Education/Training/Opportunities for growth	8	28
Peer support	9	31
One-on-one/ Hands on work	17	59
Challenging/Problem solving type of job	20	69
Autonomy/Working on Own	18	62
Variety in tasks	11	38
Work environment	15	52
Interesting people	8	28
Interactions with client family members	7	24
Providing a beneficial and less stressful environment for clients	11	38
Personal satisfaction of giving assistance	20	69
Receive appreciation from clients or client family members	14	48
Gives a positive perspective in life	7	24
Rapport with clients	21	72

N=29 Focus Groups

Table 10: Focus Groups: Negative Aspects of the Job

Item mentioned in focus groups	Number of focus groups mentioned	% of focus groups
Lack of respect from community, clients, CCAC	22	76
Lack of resources/ funding in home care	12	41
Wage inequity	13	45
Shortage of home care workers	18	62
Intense work/ Not having enough time to do the work	21	72
Unpaid overtime	10	35
Lack of information about clients prior to visit	12	41
Paper work demands of the job (filling forms, writing reports)	16	55
Work schedule issues	16	55
Demanding public expectations	11	38
Lack of education/training provided	11	38
Isolation (working alone in the home/community)	19	66
Have take work home to finish the job/ work negatively affects family and personal life	19	66
Lack of stability in employing organizations	10	35
Technology issues (not provided with technology to properly do the work, too much technology, not trained in technology, too much emphasis on technology use for communication)	9	31
Lack of control over work	13	45
Job requires physical effort	16	55
Safety hazards in clients' homes + office environment	15 + 8	51 + 28
Animals (as unhealthy work environment)	10	35
Allergy creating substances in the work environment	11	38
Risk of infectious diseases	7	24
Lack of safety equipment provided	8	28
Car accidents or near-accidents due to travelling and rushing from one to another client	15	51
Difficult clients or family members	18	62
Clients take advantage of workers good-will	11	38
Death of a client	8	28
High client expectations or complaints	20	69
Violence of clients towards them	12	41
Sexual harassment + personal harassment	6 + 3	21 + 10
Emotional labour	12	41

N=29 Focus Groups

Table 11: Focus Groups: About Agencies (Employing Organizations)

Item mentioned in focus groups	Number of focus groups mentioned	% of focus groups
Like		
Organizational support/ respect	23	79
Values/Mission/Philosophy of the Agency	14	48
Peer support	20	69
Good Communication	14	48
Dislike		
Lack of organizational support	17	59
Lack of peer support	8	28
Poor pay	18	62
Poor benefits	14	48
Poor overall compensation	10	35
Scheduling issues	15	52
Poor communication	23	79
No guaranteed hours	8	28
Pressure to take on new clients or work when sick	14	48
Various policies and procedures	17	59

Table 12: Focus Groups: Impact of Home Care Restructuring and Managed Competition on the Home Care System, Their Jobs and On Clients

Item mentioned in focus groups	**Number of focus groups mentioned**	**% of focus groups**
Impact on home care system		
Reduced quality of services	19	66
Lack of resources	26	90
Loss of preventive function/ loss of holistic approach	12	41
Impact on Their Jobs		
Heavier workload/ work intensification	20	69
Downloading	16	55
Reduced length of visits or more visits per day	14	48
Difficulties in mastering the RFP process	16	55
Less organizational support	7	24
Changes in support and relationships with other agencies or service providers	16	55
Job insecurity	12	41
Heavier workload	12	41
Unpaid work	8	28
Created a unionized environment	8	28
Impact on clients		
Higher client acuity	25	86
Higher public expectations/ awareness/ complaints	19	66
Clients falling through the cracks	17	59
Less time to give client emotional support	10	35
Less continuity in care	22	76
Impact on the work environment in general		
Higher turnover	12	41
Stability issues	14	48

N=29 Focus Groups

Table 13: Focus Groups: Health Consequences of Health Care Restructuring and Managed Competition

Item mentioned in focus groups	Number of focus groups mentioned	% of focus groups
Mental Health Consequences		
Work-related Stress	28	97
Other (family-related, personal life) stress	8	28
Burnout	6	21
Anxiety	12	41
Mental Exhaustion/ Tiredness	16	55
Depression/ Sadness	10	35
Frustration	23	79
Anger	6	21
Mistrust	8	28
Physical Health Consequences		
Musculoskeletal disorders	18	62
Respiratory illness	6	21
Colds and flues	6	21
Accidents or injuries	15	52
Physically tired/ Exhausted	15	52
Stress-related physical ailments	10	35
Nutritional or physiological issues	9	31
Headaches/ Migraines	10	35
Weight gain or loss	9	31

N=29 Focus Groups

Table 14: Focus Groups: Health Promotion

Item mentioned in focus groups	Number of focus groups mentioned	% of focus groups
Have health and safety committee	12	41
General training sessions	13	45
Training or ergonomic adjustment in client's home or office	12	41
Employer provides equipment	7	24
Supportive environment	15	52

N=29 Focus Groups

Table 15: Focus Groups: Recommended Changes to Health Care System and Their Agencies

Item mentioned in focus groups	**Number of focus groups mentioned**	**% of focus groups**
To health care system:		
Wage parity	15	52
Abandon the RFP process	10	35
Revise the RFP process	9	31
CCAC	9	31
Provide education and training	11	38
Should provide integrated/ continuum of care	12	41
Increase funding to home care	23	79
There should be changes to case managers' role + Service providers should be given more voice on the care of the client	10 + 15	35 + 52
Improve awareness of clients on home care workers' role in care	17	59
Better evaluation of who needs care and how many hours (some clients receive less than they need, some more) + give clients more hours	15 + 9	52 + 31
To agencies:		
Increase number of staff	16	55
Increase staff compensation (better pay)	20	69
Recognize experience and education in pay (provide a pay ladder)	10	35
Provide educational support, in-service training	9	31
Provide more organizational support	18	62
Improve communication (between management and workers, and between workers of different occupations)	15	52
Promote continuity of care	8	28
Seek employee participation/ involvement and provide recognition	12	41
Physical changes (provide ergonomic office equipment; provide more staff and physical space for supervisors and coordinators; should be less managers and more case managers and office staff; provide safer, free, accessible after 5:00 p.m. parking space around the downtown/city offices)	8	28
Changes to work design (teamwork to be encouraged, doctors to include home care workers in their decisions, weekend work to be less often, separate nursing care from housework for home support workers, etc.)	14	48
Clearer policies and procedures	11	38

6. DEMOGRAPHIC AND HEALTH CHARACTERISTICS OF SURVEY PARTICIPANTS

6 a) Demographic Characteristics of Respondents

The majority of home care workers responding to the Healthy Work Environments Survey (referred to in this report as home care workers) were female (94%) and 6% were male. The average (or mean) age of respondents at the time of the study was 45.0 and ages ranged from 20 to 72 (standard deviation = 10.36). Most participants (65%) were married or living with their partners, 17% were separated or divorced, 3% were widowed and 14% were never married. Approximately 77% of participants had children living with them. The age ranges of the children were less than 5 years of age (14% of respondents), 5 to 12 years of age (25% of respondents) and 13 years of age and older (38% of respondents). Some respondents (7%) had other elderly or disabled adults living with them. Approximately 13% of respondents lived alone.

Most respondents (65%) were born in Canada and 35% were born outside of Canada. Approximately 30% of respondents identified themselves as being members of ethnic groups and 11% identified themselves as being members of visible minorities.

The highest level of education of respondents ranged from only some high school to having post graduate degrees. However, most respondents (80%) held either diplomas from community colleges (28%), certificates from community colleges (21%) some university or university degrees (27%) and postgraduate degrees (4%). Approximately 16% of respondents completed college training in nursing.

Respondents were asked how much they personally contribute to their total family incomes. While 16% of respondents said they contribute from 0% to 25%, about 34% of respondents said they contribute 76% to 100% of their incomes to support their families. About one-half of the respondents said they contribute mid ranges of 26% to 76% of their incomes to support their families.

Home care workers were employed in a variety of occupations including both visiting and office staff. Table 16 summarizes the actual job titles respondents had at the time of the study. The majority of respondents in the study were those who work in clients' homes. These were home support workers, nurses and therapists. Office staff included managers, supervisors, coordinators and support staff. Case managers work both in the office and do client visits in the home.

Table 16: Job Titles of Respondents

Job Title	Respondents in each job title	% of total (N=1311)
Managers	36	2.8
Supervisors	37	2.9
Coordinators	35	2.7
Support Staff	107	8.3
Case Managers	85	6.6
Nurses	228	17.7
Therapists	84	6.5
Home Support Workers	678	52.5
Total	1290	100
Missing	21	

Respondents had spent an average of 11.8 years in their professions and had worked for their current employers an average of 6.1 years. Their positions were full-time (55%), part-time (32%) and casual (13%). At the time of the study, almost 20% of respondents had second jobs as health care providers at other agencies. Three-quarters of all respondents stated that they work in clients' homes.

6 b) Physical Health Status

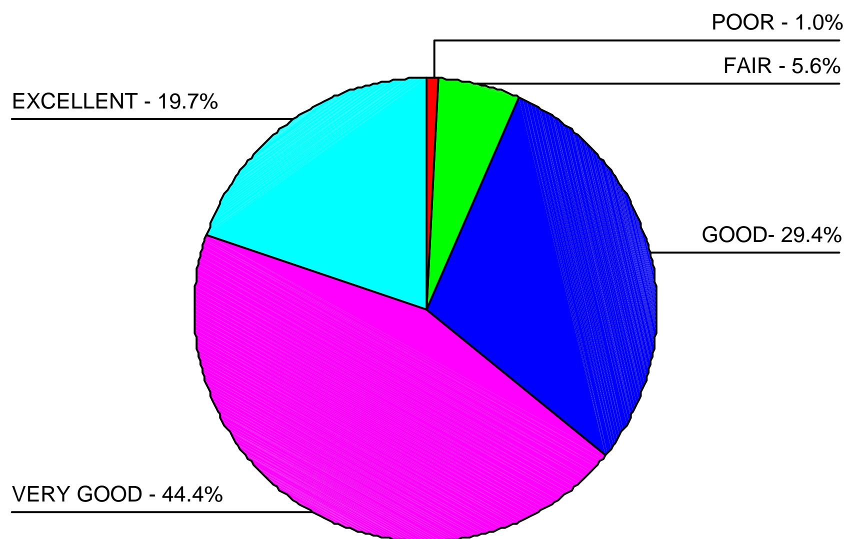
Home care workers at the eleven participating agencies were asked a series of questions to gauge their physical health. These included questions on self-rated health, health conditions diagnosed by health care professionals, a series of questions on work-related injuries over the past year, days absent from work due to illness or injury, and questions on musculoskeletal disorders.

A number of the health questions asked in the survey replicated questions asked in the National Population Health Survey (NPHS).[133] Where applicable, we compared our survey results to a sub sample of all working women from the NPHS. This allows us to draw some conclusions about the extent of health problems experienced by our sample of home care workers compared to the sample of working women, aged 20-64.

6 b) 1. Overall Health of Participants at the Time of the Study

The vast majority of employees at all 11 agencies (93.5%) described their overall health as good, very good or excellent and approximately 6.5% described their health as being fair or poor (Figure 2). The reported health status of home care workers is slightly worse than responses to the same question of a large sample (N=4092) of Canadians working women in the general population.[133] In the National Survey, 95.4% of respondents described their health as excellent, good or very good and 4.6% described their health as fair or poor.

Figure 2: How would you describe your health?



6 b) 2. Current Physical Health Conditions

The three most frequently reported health conditions of home care workers, as diagnosed by health care professionals, were allergies, back problems and arthritis or rheumatism. Nearly one-fifth of respondents reported having either carpal tunnel syndrome or another work-related musculoskeletal disorder. Some respondents reported having more than one health problem (Table 17).

Table 17: Current Diagnosed Health Conditions

Health Condition	Home Care Workers	% of total (N=1311)	Working Women aged 20-64 (NPHS)	% of total (N=3852)
Allergies	379	28.9	1523	39.5
Back Problems	345	26.5	569	14.8
Arthritis or Rheumatism	284	21.7	476	12.4
Migraine Headaches	249	19.0	508	13.2
High Blood Pressure	147	11.2	269	7.0
Asthma	136	10.4	338	8.8
Work-related musculoskeletal disorder	130	9.9	N/A	N/A
Carpal Tunnel Syndrome	110	8.4	N/A	N/A
Stomach or intestinal ulcers	57	4.3	107	2.8
Bronchitis	32	2.4	84	2.2
Cancer	27	2.1	34	.9
Heart disease	21	1.6	47	1.2
Other	162	12.4	273	7.1
Total # of health problems	2079		4228	

Comparisons of these results with those for working women aged 20-64 responding to the 1998 National Population Health Survey (NPHS) were made. The percentage of respondents having back problems in this study (26.5%) was much greater than that among working women in the general population (14.8%). Home Care Workers were also more likely to have rheumatism or arthritis, migraine headaches, high blood pressure and stomach or intestinal disorders than working women in the National Population Health Survey.

6 b) 3. Work-Related Injuries over the Past Year

Over the past year, 157 home care employees (12.0% of all respondents) reported having at least one work-related injury that was serious enough to limit their normal activities. Of these, 41 (26.1% of those injured or 2.2% of all participants), reported having two or more work-related injuries. The number of work-related injuries reported by participants ranged from 1 to 5. Table 18 indicates the number of employees who had one or more work-related injury. The percentages given are based on only those who were injured at work and the percentages of all respondents surveyed.

Table 18: Number of Work-Related Injuries

Number of Injuries	Number of injuries	% of workers injured (N=157)	% of Total (N=1311)	Properties
1	108	72.5	8.2	Mean:1.3 Range: 1-5 SD: 0.75
2	28	18.8	2.1	
>2	13	8.7	1	
Total	149	100	11.3	
Missing	8			

Types of Injuries

The most common types of work-related injuries reported were: sprains and strains (65.0%), bruises and abrasions (9.5%) and cuts and scrapes (8.3%). Almost 28% of those employees injured (or 3% of all employees) reported their injuries as "other" than those listed.

Table 19: Types of Work-Related Injuries

Types of Injuries	Number of each injury	% of workers injured (N=157)	% of Total (N=1311)
Sprain or strain	102	65.0	7.8
Bruise or abrasion	15	9.5	1.1
Cut or scrape	13	8.3	.99
Broken bones	10	6.4	.76
Dislocation	9	5.7	.68
Internal injury	5	3.2	.38
Burn or scald	3	1.9	.22
Other	43	27.4	3.2
Total	200		

Body Parts Injured

The most common injuries were those to the back or spine, arms or hands and shoulder and neck. Almost one-half (45%) of all respondents who reported injuries over the previous year stated that two or more body parts were injured.

Table 20: Body Parts Injured

Body Part Injured	Number of each body part injured	% of workers injured (N=157)	% of Total (N=1311)
Back or spine	83	52.9	6.3
Arms or hands	44	28.0	3.4
Shoulder	43	27.4	3.3
Neck	38	24.2	2.9
Hip	14	8.9	1.1
Feet	13	8.3	1.0
Head	4	2.5	0.3
Trunk	3	1.9	0.2
Eyes	2	1.3	0.2
Other	38	24.2	2.9
Total	282		

Location where Injuries Occurred

Respondents were asked where their injuries took place. Nearly half of those workers who were injured reported that their injuries took place inside clients' homes. Another 31% of respondents reported that their injuries took place either travelling to clients' homes or just outside clients' homes.

Table 21: Location Where Injuries Took Place

Location where injuries took place	Number of injuries that took place	% of workers injured (N=157)	% of Total (N=1311)
Inside a client's home	76	48.4	5.8
Traveling to a client's home	26	16.6	2.0
No specific location	23	14.6	1.7
Outside a client's home	22	14.0	1.7
In the office	21	13.4	1.6
Other location	16	10.2	1.2
Total	184		

How Injuries Occurred

Employees were asked how their injuries occurred. The most common causes of injuries that occurred were repetitive strains, accidental falls and injuries resulting from protecting clients from falls.

Table 22: How Injuries Occurred

How injuries occurred	Number of each injury	% of workers injured (N=157)	% of Total (N=1311)
As a result of a repetitive strain	68	43.3	5.2
Accidental fall	38	24.5	3.0
When protecting a client from a fall	24	15.3	1.8
Physical assault by a client	6	3.8	0.5
Needle stick injury	3	1.9	0.2
Animal bite	2	1.3	0.1
Physical assault by client's family member	1	0.6	.07
Other	42	26.7	3.2
Total	184	-	14.0

Reports of Injuries to Agencies or to the WSIB

Respondents were asked if they reported their injuries to their agencies and/or to the WSIB. During 2001, 140 respondents (89% of those injured) reported their injuries to their agencies and 101 respondents (64% of those injured) reported their injuries to the WSIB. Individuals making reports to the WSIB represented 7.7% of all employees surveyed.

Most respondents who reported their injuries to the WSIB only reported one injury. However, 16 respondents reported two or more injuries. Of those workers making WSIB claims, 60 individuals (59.4%) received compensation for their injuries.

Table 23: Reports of Injuries

Reports of Injuries	Number of injuries reported	% of workers injured (N=157)	% of all study participants (N=1311)
To Agencies	140	89.2	10.6
To WSIB	101	64.3	7.7

The employees who reported their injuries to the WSIB were Home Support Workers (74%), Nurses (16%), Case Managers (5%) and Support staff (5%). Most respondents (76.2) who were injured received treatment for their injuries either from their family doctors, hospitals or clinics.

6 c) Workplace Harassment/Violence

Some respondents (8.8%) also experienced violence or the threat of violence in the workplace during the past year. Of those respondents, fifty nine percent experienced violence two or more times. Their aggressors were clients (73.8%), relatives or visitors of clients (31.7%), co-workers (7.3%) and strangers (4.9%). These respondents were victims of verbal threats (81.1%), spitting (13.1%), biting (9.0%), scratching or pinching (22.1%), slapping or hitting (21.3%), punching (8.2%), pushing (26.2%), kicking (13.1%), restraining (4.1%), sexual assault (4.1%), sexual harassment (14.8%) and use of objects or weapons (8.2%).

6 d) Specific Musculoskeletal Disorders

Musculoskeletal Disorders (MSDs) are defined in Hales and Bernard as disorders of the soft tissue and surrounding structures, not resulting from an acute or instantaneous event.[103] These disorders occur in the neck, shoulder, elbow, hand, wrist, lower back, ankles and feet. Respondents rated how often they experienced each symptom on a 5-point scale ranging from none of the time to all of the time over the past few months (See Table 24). The data show the following MSDs are experienced some, most or all of the time by home care workers: 42% experience back pain; 39% experience pain in the neck or shoulder; 26% experience pain in the elbow or hand; 22% experience pain in the knees; 21% experience pain in the ankles or feet; 19% experience sore or sprained muscles; 17% experience pain in the hips.

Table 24: Specific Musculoskeletal Disorders Experienced in the Past Few Months

Musculoskeletal Disorders	None/A little of the Time N (%)	Some of the Time N (%)	All/Most of the Time N (%)	Scale Properties
Back Pain	739 (57.7)	430 (33.6)	112 (8.8)	N=1311 Mean: 12.98 SD: 4.67 Range: 7-35 Alpha: .80
Pain in Neck or Shoulder	780 (60.8)	355 (27.7)	147 (11.5)	
Pain in Elbow or Hand	937 (73.8)	244 (19.2)	88 (6.9)	
Pain in Knees	997 (78.1)	215 (16.8)	65 (5.1)	
Pain in Ankles or Feet	1013 (79.3)	177 (13.8)	88 (6.8)	
Sore or Sprained Muscles	1022 (81.0)	177 (14.0)	63 (4.9)	
Pain in Hips	1051 (82.6)	158 (12.4)	63 (4.9)	

As discussed in Zeytinoglu et al.[7], these seven measures were used to create a Musculoskeletal Disorder (MSD) scale by summing the responses to these questions. Possible MSD scores range from 7 to 35. The higher the scores, the more extensive the MSD. A Cronbach's alpha was calculated to determine the reliability of the items making up the MSD scale. The Alpha was .80, indicating high internal reliability of the MSD scale.

The average score among all study participants was 12.9 and scores varied by the professions of respondents. Scores were lowest among supervisors, therapists and managers and highest among case managers and support staff. Nurses and home support workers had moderately high scores of 12.9 and 13.2, respectively (Table 25).

Table 25: Mean MSD Scores by Profession

Profession	Respondents in each profession	Mean MSD Score	Standard Deviation
Managers	36	11.9	4.0
Supervisors	37	11.2	3.4
Coordinators	35	12.2	4.0
Support Staff	107	13.3	4.7
Case Managers	85	14.2	4.7
Nurses	228	12.9	4.8
Therapists	84	11.7	4.0
Home Support Workers	678	13.2	4.7
Total – Group mean	1290	12.9	4.6
Missing	21		

N=1311

6 e) Mental Health

The survey questionnaire contained several measures including life stress, job stress, and a measure of symptoms of stress. Maslach Burnout Inventory[134] was used to measure emotional exhaustion, depersonalization and personal accomplishment. Measures of psychological resources are self-esteem and mastery. The section below presents the results on stress.

6 e) 1. Stress

In the first measure of stress, respondents were asked to describe overall how stressful their lives were on a five point scale from 1 being not at all stressful to 5 being very stressful. The same question was repeated about their jobs. As shown in Figures 3 and 4, almost one-quarter of all respondents rated their lives as being stressful or very stressful. One-half of all respondents rated their lives as somewhat stressful. Another one-quarter of respondents rated their lives as being not at all stressful or not very stressful.

There was a similar distribution for how stressful respondents rated their jobs. Participants rated their jobs as being stressful or very stressful (28.1%), somewhat stressful (47%) and not at all stressful or not very stressful (25.0%).

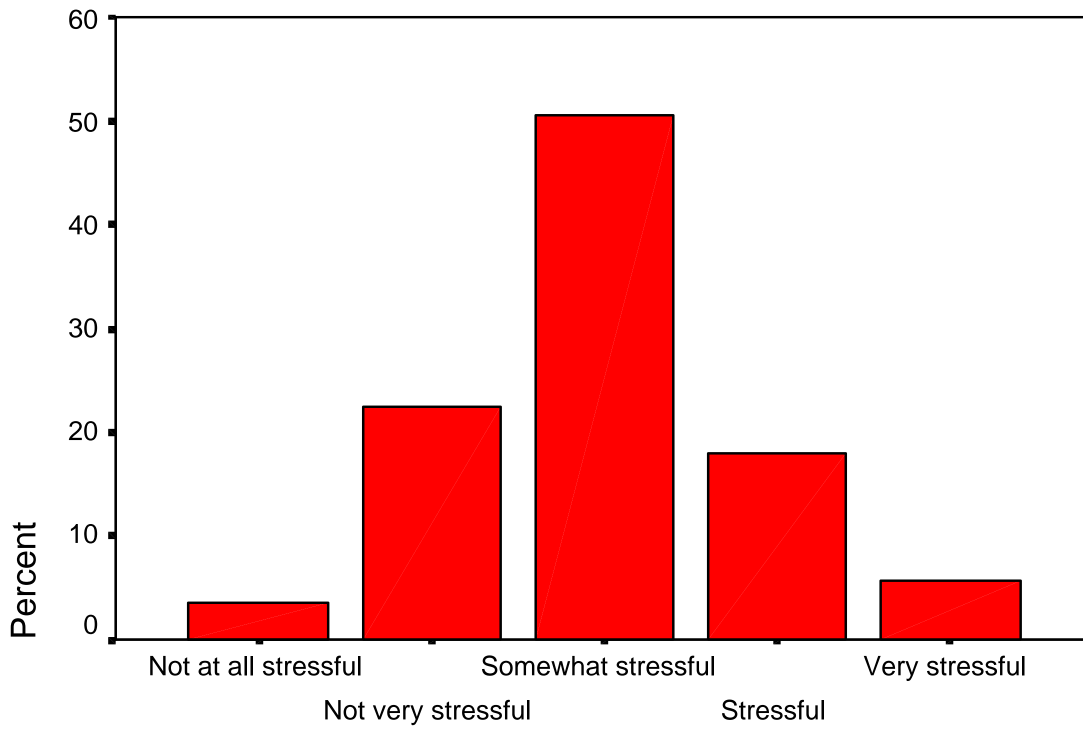


Figure 3: Would you describe your life as being:
Percent
60
50
40
30
20
10
0
Not at all stressful
Not very stressful
Somewhat stressful
Stressful
Very stressful

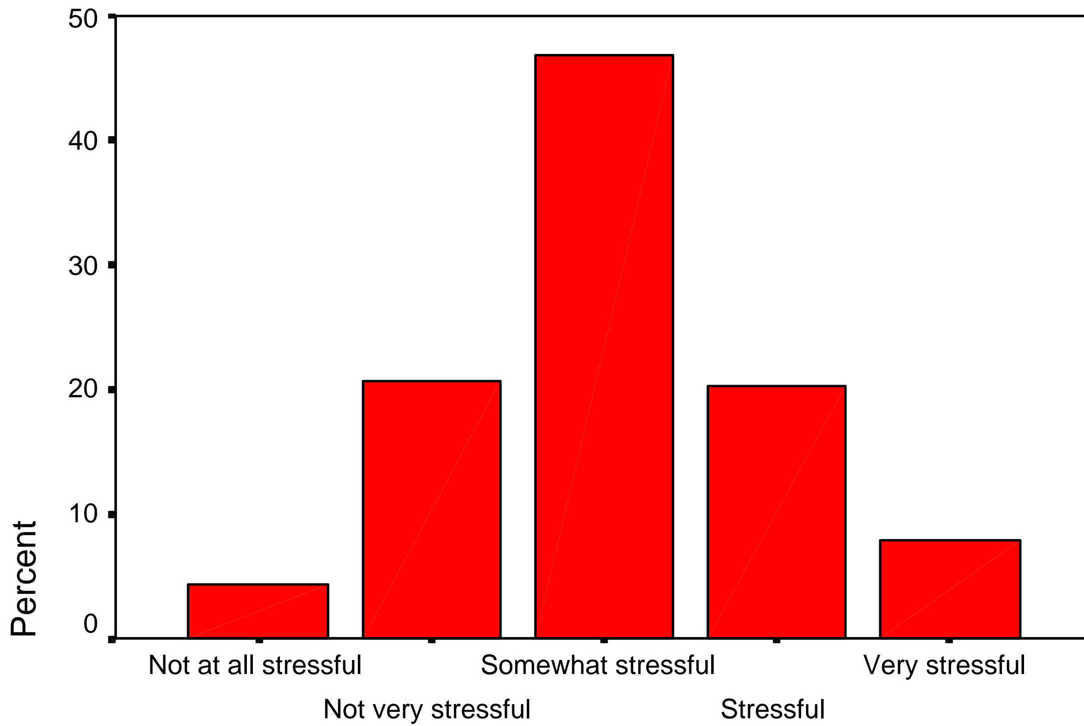


Figure 4: Would you describe your job as being:
Percent
50
40
30
20
10
0
Not at all stressful
Not very stressful
Somewhat stressful
Stressful
Very stressful

:

In the second measure of stress, respondents were presented with fourteen symptoms of stress. They were asked (on a 5-point scale ranging from none of the time to all of the time) how often they had felt this way during the past month. The most frequently reported (some, most or all of the time) symptoms of stress were: 70% reported being exhausted at the end of the day; 57% did not feel energized on the job; 42% reported being unable to sleep through the night; 39% felt burnt out; 34% felt irritable and tense; 31% reported migraines; 29% felt not in control of their life; 28% felt like there is nothing more to give; 25% felt like crying; 25% had difficulty concentrating; 23% felt angry; 23% felt helpless; 17% felt like yelling at people; and 11% felt dizzy (See Table 26).

Table 26: Symptoms of Stress Felt During the Past Month

Symptom of Stress **During the past month, how often have you felt:**	**None or a little of the time N (%)**	**Some of the time N (%)**	**Most or all of the time N (%)**	**Scale Properties**
Exhausted at the end of the day	394 (30.4)	520 (40.1)	384 (29.6)	N=1311 Mean: 29.6 SD: 7.5 Range:14-70 Alpha: .84
Headaches or migraines	889 (69.1)	337 (26.2)	61 (4.8)	
Able to sleep through the night*	273 (21.1)	275 (21.2)	747 (57.7)	
Felt like crying	961 (74.6)	283 (22.0)	44 (3.5)	
Energized on the job*	325 (25.6)	405 (31.9)	540 (42.5)	
Burnt out	788 (60.9)	363 (28.1)	142 (11.0)	
Like yelling at people	1080 (85.3)	182 (14.1)	32 (2.5)	
Like there is nothing more to give	919 (72.2)	257 (20.2)	96 (7.5)	
Difficulty concentrating	976 (75.5)	264 (20.4)	53 (4.1)	
Angry	993 (76.8)	272 (21.1)	27 (2.1)	
Helpless	990 (76.6)	238 (18.4)	65 (5.1)	
In control of your life*	146 (11.4)	226 (17.6)	914 (71.1)	
Irritable and tense	852 (66.1)	369 (28.6)	68 (5.2)	
Dizzy	1152 (89.2)	127 (9.8)	12 (1.0)	

*Scores were reversed for these items in constructing the scale.

As discussed in Denton et al.[3] a measure of stress was obtained by summing the 14 stress symptoms to form a stress scale. Stress scores ranged from 14 to 70 with higher scores indicating more stress. The mean stress scale score for all participants was 29.6 (standard deviation 7.5). A Cronbach's alpha of .84 indicated good internal reliability of the stress scale.

Scores on the various stress measures varied by occupation. Case managers, managers, coordinators and supervisors had higher than average overall stress and job stress scores as seen in Table 27. Results differed for the symptom of stress scale. On this measure, which measures the negative effects of stress, managers ranked lower than average, while case managers, coordinators and supervisors had higher than average scores.

Table 27: Mean Stress Scores by Profession

Profession	Number of respondents in each profession	How stressful is your life?	How stressful is your job?	N	Mean Stress Scale Scores
Managers	36	3.44	3.81	29	26.8
Supervisors	37	3.30	3.38	35	32.1
Coordinators	35	3.23	3.69	30	33.0
Other Support Staff	107	2.91	3.08	89	31.1
Case Managers	85	3.42	3.95	78	34.9
Nurses	228	3.04	3.19	206	29.4
Therapists	84	3.21	3.33	81	29.3
Home Support Workers	678	2.87	2.79	516	28.7
Total	1290	3.0	3.0	1064	29.6

The differences by occupation reflect the literature that shows that stress in people's lives can have both a positive and negative effect. It has been shown for example, that some stress can have positive health effects; but too much stress may be harmful. The job stress reported by the managers is not reflected in the symptoms of stress scale. On the other hand, the stress experienced by case managers, supervisors and coordinators is reflected in the symptoms of stress. This finding will be further clarified when we consider the scores on the Burnout Scales and self-esteem and mastery.

6 e) Burnout

The Maslach Burnout Inventory[134] is sub-divided into three separate scales: emotional exhaustion, depersonalization and personal accomplishment. Respondents were given a set of twenty-two questions and asked how often (on a five-point scale) they felt this way over the past month (See Table 28). These scores were then summed to construct the three scales.

The nine items of the Emotional Exhaustion scale describe feelings of being overextended and exhausted by one's work. The five items on the Depersonalization scale describe impersonal and unfeeling responses toward clients receiving care. The eight items on the Personal Accomplishment scale describe feelings of accomplishment and professional achievement on the job. There are some important differences by occupation on these three scales.

The mean score for Emotional Exhaustion for all respondents was 19.1 (standard deviation = 6.25) and scores ranged from 9 (low) to 45 (high). This indicates that home care workers, on average, were experiencing moderate degrees of emotional exhaustion at their jobs. Case managers, coordinators and supervisors experienced the highest level of emotional exhaustion, while nurses and home support workers experienced the least amount of emotional exhaustion.

Table 28: Burnout Inventory

Burnout Items How often have you felt each of the following over the past month:	None or a little of the time N (%)	Some of the time N (%)	Most or all of the time N (%)	Scale Properties
Emotional Exhaustion				Mean: 19.1 SD: 6.25 Range: 9-45 Alpha: .88
I feel emotionally drained from my work	647 (50.2)	470 (36.5)	172 (13.4)	
I feel used up at the end of the workday	644 (50.2)	402 (31.4)	236 (18.4)	
I feel fatigued when I get up in the morning and have to face another day on the job	812 (63.2)	324 (25.2)	149 (11.6)	
Working with people all day is really a strain on me	1031 (80.7)	212 (16.6)	34 (2.7)	
I feel burned out from my work	849 (66.4)	308 (24.1)	122 (9.5)	
I feel frustrated by my job	777 (60.7)	372 (29.0)	132 (10.3)	
I feel I'm working too hard on my job	635 (49.6)	408 (31.9)	236 (18.5)	
Working with people directly puts too much stress on me	1104 (86.5)	151 (11.8)	21 (1.7)	
I feel like I'm at the end of my rope	1103 (86.7)	138 (10.8)	32 (2.5)	
Depersonalization				Mean: 7.2 SD: 2.44 Range: 5-25 Alpha: .61
I feel I treat some clients as if they were impersonal "objects"	1163 (93.6)	65 (5.2)	15 (1.2)	
I've become more callous toward people since I took this job	1001 (84.0)	128 (10.7)	61 (5.1)	
I worry that this job is hardening me emotionally	1067 (84.3)	157 (12.4)	41 (3.2)	
I don't really care what happens to some clients	1204 (95.3)	32 (2.5)	27 (1.4)	
I feel clients blame me for some of their problems	1045 (82.1)	187 (14.7)	40 (.8)	
Personal Accomplishment				Mean: 29.8 SD: 4.28 Range: 8-40 Alpha: .76
I can easily understand how my clients feel about things	66 (5.2)	225 (17.7)	979 (77.1)	
I deal effectively with the problems of clients	69 (5.5)	118 (9.4)	1075 (85.2)	
I feel I'm positively influencing other people's lives through my work	153 (12.2)	253 (20.2)	848 (67.6)	
I feel very energetic	268 (20.9)	393 (30.8)	615 (48.3)	
I can easily create a relaxed atmosphere with clients	86 (6.8)	180 (14.2)	1002 (79.0)	
I feel exhilarated after working closely with my clients	239 (19.8)	419 (34.8)	547 (45.4)	
I have accomplished many worthwhile things in this job	86 (6.8)	267 (21.0)	918 (72.3)	
In my work, I deal with emotional problems calmly	75 (5.9)	151 (11.8)	1056 (82.4)	

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N=1311

The sample mean on the Depersonalization scale was 7.2 (standard deviation =2.44) with scores ranging from 5 (low range) to 21 (high range). The low mean indicates that overall, depersonalization is not an issue for home care workers. Case managers, coordinators, support staff and supervisors, however, had the highest average depersonalization scores, while nurses and home support workers had the lowest average depersonalization scores.

Scores on Personal Accomplishment ranged from 11 to 40, with higher scores indicating higher degrees of personal accomplishment. The sample mean was 29.8 (standard deviation = 4.28) and average scores for all job categories were in the high range. This indicates that home care workers, as a group, experience a relatively high degree of personal accomplishment from their work. Again, personal accomplishment scores varied by occupation. The respondents receiving the most personal accomplishment from their work were the managers.

These results shed some light on the occupational differences in the symptoms of stress scale. The work-related stress experienced by the case managers, coordinators and supervisors were more likely to lead to feelings of emotional exhaustion and depersonalization. The work-related stress experienced by the managers was a more positive force associated with feelings of personal accomplishment on the job.

Table 29: Mean Scores – Maslach Burnout Inventory Subscales by Occupation

Profession	Number of respondents in each profession	Emotional Exhaustion	Depersonal-ization	Personal Accomplish-ment
Managers	36	19.7	7.0	31.7
Supervisors	37	20.9	8.3	29.5
Coordinators	35	21.9	8.7	29.1
Other Support Staff	107	19.3	7.5	28.2
Case Managers	85	23.4	8.9	28.8
Nurses	228	18.8	6.5	30.5
Therapists	84	19.5	7.3	30.1
Home Support Workers	678	18.3	7.0	29.9
Total (Mean)	1290	(19.1)	(7.2)	(29.8)

6 e) 3 Self-Esteem and Mastery

Psychological resources are measured by two scales, self-esteem and mastery. As discussed in Pearlin & Schooler[135, p.5], self-esteem refers to "the positiveness of one's attitude towards oneself" and mastery or perceived control is the "extent to which one regards one's life chances as being under one's own control in contrast to being fatalistically ruled". Self-esteem is measured by a six item index (scale 6 to 30) and mastery is measured by a seven-item mastery index (scale 7 to 35). Higher scores indicate greater self-esteem and mastery.

Table 30: Self-Esteem Scale

Do you agree or disagree with each of the following:	Strongly Disagree/ Disagree N (%)	Neither agree nor disagree N (%)	Strongly agree/ Agree N (%)	Scale Propert-ies
You feel that you have a number of good qualities	8 (.6)	21 (1.6)	1275 (97.8)	N=1311 Mean: 25.6 SD: 3.26 Range: 6-30 Alpha: 0.82
You feel that you are a person of worth, at least equal to others	23 (1.8)	51 (3.9)	1220 (94.3)	
You are able to do things as well as most people	17 (1.3)	67 (5.1)	1217 (93.6)	
You take a positive attitude towards yourself	53 (4.1)	125 (9.6)	1119 (86.2)	
On the whole, you are satisfied with yourself	101 (7.8)	161 (12.4)	1037 (79.8)	
All in all, you're inclined to feel a failure *	1088 (84.3)	130 (10.1)	73 (5.7)	

* Item was reversed in the scale

Table 31: Mastery Scale

Do you agree or disagree with each of the following:	Strongly Disagree/ Disagree N (%)	Neither agree nor disagree N (%)	Strongly agree/ Agree N (%)	Scale Propert-ies
You have little control over the things that happen to you *	825 (63.5)	270 (20.8)	204 (15.7)	N=1311 Mean: 26.7 SD: 4.68 Range: 7-35 Alpha: 0.80
There is really no way you can solve some of the problems you have *	862 (66.4)	199 (15.3)	237 (18.2)	
There is little you can do to change many of the important things in your life *	955 (74.4)	163 (12.7)	166 (12.9)	
You often feel helpless in dealing with problems in life *	934 (72.1)	195 (15.0)	167 (12.9)	
Sometimes you feel that you are being pushed around in life *	714 (55.3)	255 (19.8)	322 (25.0)	
What happens to you in the future mostly depends on you	86 (6.7)	174 (13.5)	1032 (79.9)	
You can do just about anything you really set your mind to	66 (5.1)	149 (11.5)	1083 (83.4)	

* Items were reversed in the scale

In general, home care workers have high levels of self-esteem and mastery, or a sense of control over their lives. Total average scores on both scales did not vary greatly by occupation, although managers did report higher self-esteem and mastery than the other groups. Average scores by occupation ranged from 25 to 28 for self-esteem and from 26 to 28 for mastery.

Table 32: Self-Esteem and Mastery Scale by Occupation

Profession	Number of respondents in each profession	Self- Esteem	Mastery
Managers	36	27.8	28.5
Supervisors	37	25.9	27.9
Coordinators	35	26.8	26.7
Other Support Staff	107	25.6	26.4
Case Managers	85	26.4	27.3
Nurses	228	25.8	27.1
Therapists	84	25.7	27.9
Home Support Workers	678	25.3	26.2
Sample Mean	1290	25.6	26.7

N=1311

7. HEALTH CARE RESTUCTURING

7 a) Changes in Home Care Since 1997 (The Introduction of Managed Competition)

One objective of this research was to study the impact of health care restructuring and organizational changes on the mental and physical health of home care workers. The literature review described these changes and information from the key informant interviews and focus group discussions detailed how these changes had impacted on the organization, on the home care workers and on the clients.

Two-thirds of the survey respondents (64%, N=822) had worked in the home care sector during or prior to 1997 (prior to the introduction of managed competition), and of these, 76% had been employed by the same agency. For the purpose of this analysis, we refer to these respondents as long-term employees/home care workers.

We presented these long-term employees with a series of statements that people might use to describe changes in the home care field and changes in their job. We asked them to compare the present time to 1997, and tell us if they agreed or disagreed (on a 5 point Likert scale from strongly disagree to strongly agree) with each statement. Several themes emerged: 1) there has been a shift to a business focus in home care; 2) the intensity of the work has increased; 3) there is a lack of resources; 4) there are staff shortages; 5) there has been an increase in client acuity; and 6) there has been a decrease in the quality of care provided to clients. The percent of long-term employees who agree with the following statements describing each of these themes is presented below. Six new summative scales were constructed to identify these trends and their means, standard deviations, range and reliability coefficients are provided in the table below (See Appendix A for detailed results).

In addition, we asked those long-term home care workers who travel to clients' homes if the amount of time they spent traveling had changed since 1997. For most workers, the amount of travel time was either reduced (41.2%) or remained the same (32.1%) since 1997. However, 27% of respondents indicated that their travel time to and from clients' homes had increased since 1997.

An additional question asked long-term home care workers to compare their current benefits to those they received in 1997. Over one-half of the respondents (55.7%) disagreed that their benefits were better in 1997.

We also asked these home care workers if they had witnessed a change in stress levels since 1997. Over 79% agreed that stress levels of home care workers had increased.

Table 33: Changes in Home Care Since 1997

To what extent do you agree/disagree with each of the following statements?	Strongly Agree/ Agree	Scale Properties
Shift to a Business Focus since 1997		
Home Care is more "business-like"	72%	Mean: 17.3. SD: 3.12 Range: 5-25 Alpha:.78
There is more emphasis on productivity at your agency	57%	
There is less emphasis on preventive care for clients	41%	
There is less emphasis on care for the whole person	47%	
There is less cooperation between home care agencies	42%	
Individual Effects of Shift to Business Focus		Mean: 9.06 SD: 2.04 Range: 3-15 Alpha: .64
I receive less support from my coworkers	23%	
I receive less support from managers or supervisors	31%	
I have less job security	55%	
Work Intensification Since 1997		
My workload is heavier	62%	Mean: 21.3 SD: 3.56 Range: 6 – 30 Alpha: .77
There is pressure to do more with less time	86%	
I work more evenings and week-ends	28%	
The amount of unpaid work I do has increased	42%	
The skills required to do my job have increased	73%	
My job is more complex	70%	
Lack of Resources		
There is a shortage of resources in the home care field	90%	Mean: 17.2 SD: 1.88 Range: 4 – 20 Alpha: .73
Families of clients are expected to provide more care	92%	
Home care workers now do tasks that were once nursing tasks	80%	
Nurses now do tasks that were once done in hospital	85%	
Staff Shortages		Mean: 10.2 SD: 2.07 Range: 3 – 15 Alpha: .73
There are more staff shortages at your agency	42%	
There is more staff turnover at your agency	49%	
There are more staff shortages in the home care field	60%	
Greater Client Acuity		
Home care clients are sicker	71%	Mean: 12.4 SD: 1.66 Range: 3 – 15 Alpha: .72
Some clients are discharged more quickly from the hospital	95%	
The care given to home care clients is more complex	81%	
Decreased Quality of Care		
The quality of home care in general has decreased	64%	Mean: 6.5 SD: 1.66 Range: 2 – 10 Alpha: .66
The quality of home care delivered by your agency has decreased	37%	

N=822

7 b) Opinions about Restructuring and Managed Competition Held by All Respondents

Respondents (N=1311) were very concerned about restructuring within the home care system. Approximately 70% of workers were concerned about losing their jobs because of overall changes in the long-term care sector. Over one-half of all workers (54.2%) were concerned about losing their jobs because of the potential of their agencies losing their contracts with the Community Care Access Centre. The majority of respondents felt that the system of managed competition should be either changed (71.1%) or ended completely (60.7%). Almost all respondents (90%) agreed or strongly agreed with the statement that “wages for home care workers should be the same across the province so that agencies can compete for contracts on quality, not price.” Approximately 70% of respondents thought that managed competition has a negative impact on the continuity of care clients receive. Most respondents (92%) felt that home care workers should be paid the same amount as workers in hospitals and nursing homes, who do the same or similar work.

8. ORGANIZATIONAL AND INDIVIDUAL OUTCOMES FACTORS

In this study we have included six organizational and individual outcome measures: job satisfaction, intrinsic job satisfaction, extrinsic job satisfaction, absenteeism, job insecurity and propensity to leave.

8 a) Job Satisfaction

Respondents were asked, overall how satisfied they were with their job. The majority of home care workers (64%) were satisfied or very satisfied with their jobs, while almost 15% of respondents were dissatisfied. Approximately 22% of respondents stated that they were neither satisfied nor dissatisfied.

Table 34: Overall Job Satisfaction

Satisfaction	N (%)
Very dissatisfied	35 (2.7)
Dissatisfied	152 (11.9)
Neither satisfied nor dissatisfied	277 (21.6)
Satisfied	689 (53.7)
Very satisfied	129 (10.1)
Total	1282 (100)

N=1311

To examine job satisfaction in more depth, we asked a series of three questions that form an intrinsic job satisfaction scale. Intrinsic job satisfaction refers to the satisfaction people receive from their work due to internal factors such as experiencing a sense of accomplishment and a purpose in life. As a group, home care workers have a high level of intrinsic job satisfaction. The vast majority (87%) believed that they get a sense of accomplishment from their jobs and that their jobs are interesting to them (80%).

Table 35: Intrinsic Job Satisfaction

Do you agree/disagree with each of the following statements?	Strongly disagree/ Disagree N (%)	Neither agree/ Disagree N (%)	Strongly agree/ Agree N (%)	Scale Properties
You get a sense of accomplishment from your job	51 (4.0)	112 (8.7)	1119 (87.3)	N=1311 Mean: 11.8 Range: 3-15 SD: 1.90 Alpha: 0.72
Your job gives you a sense of purpose in life – a reason to get up in the morning	129 (10.0)	284 (22.1)	874 (67.9)	
Your job is interesting to you	55 (4.3)	196 (15.3)	1030 (80.4)	

We also asked respondents about their extrinsic job satisfaction. Extrinsic job satisfaction refers to a sense of satisfaction people receive from their work due to more external factors such as good pay, benefits and job security. Extrinsic job satisfaction is low for a substantial number of home care respondents. Less than one-third of respondents agreed that their job security is good, that they are fairly paid, and that their benefits are good. Only 13% felt that their chances for promotion are good.

Table 36: Extrinsic Job Satisfaction

Do you agree/disagree with each of the following statements?	**Strongly disagree/ Disagree N (%)**	**Neither agree/ Disagree N (%)**	**Strongly agree/ Agree N (%)**	**Scale Propert-ies**
Your job security is good	445 (35.0)	441 (33.6)	386 (30.4)	N=1311 Mean:10.8 Range: 4-20 SD: 2.9 Alpha: 0.60
You feel that you are fairly paid	533 (41.7)	292 (22.8)	454 (35.5)	
Your benefits are good	523 (41.8)	376 (30.1)	351 (28.1)	
Your chances for promotion are good	664 (52.5)	435 (34.4)	166 (13.1)	

8 b) Absenteeism

Absenteeism is measured by the number of days respondents were absent from work over the previous year. On average, respondents were absent for 7.3 days during the previous year. Days absent from work ranged from 0 to 210 days per year with a standard deviation of 18.8.

8c) Job Insecurity

Job insecurity is a measure of peoples' perceptions of how secure their jobs are currently and will be in the future. Ten items were summed to construct the scale. Higher scores indicate greater job insecurity.

Respondents were experiencing a moderate degree of job insecurity at the time of this study. For example, almost 17% of respondents agreed with the statement "I am likely to be laid off at this agency". Approximately 43% of respondents stated that they were worried about their job security. (See Table 37)

8 d) Propensity to Leave

Propensity to leave is measured by three items that describe the respondent's interest in leaving employment at their agency. It was measured by three questions that were reversed coded to gauge propensity to leave. As shown in Table 38, the scores ranged from 3 to 15, with higher scores indicated a higher level of propensity to leave. The average score was low at 6.8. Table 38 shows that about one-in-ten respondents had a propensity to leave.

Table 37: Job Insecurity

Do you agree/disagree with each of the following statements?	Strongly disagree/ Disagree N (%)	Neither agree/ Disagree N (%)	Strongly agree/ Agree N (%)	Scale Properties
I am presently safe from dismissal at this agency *	375 (29.5)	341 (26.8)	555 (43.6)	N=1311 Mean: 27.1 SD: 7.58 Range: 10-50 Alpha: 0.86
I am confident that this agency will remain a steady place of employment for as long as I want to continue working here *	343 (26.7)	396 (30.8)	547 (42.5)	
My feelings about my future with this agency have a negative influence on my overall attitude toward my job	799 (63.0)	300 (23.6)	170 (13.4)	
The way the future looks to me now, hard work seems almost worthless	810 (63.7)	261 (20.5)	211 (15.8)	
I am not getting ahead at this agency	454 (35.8)	443 (34.8)	373 (29.3)	
I feel uneasy about the security in my present job	430 (33.8)	334 (26.1)	509 (40.1)	
I feel I am likely to be laid off at this agency	670 (52.5)	394 (30.9)	211 (16.6)	
I am likely to be employed in this job three months from now *	179 (14.3)	285 (22.8)	787 (62.9)	
I am worried about my future with this agency	471 (36.8)	368 (28.8)	441 (34.5)	
I am worried about my job security	423 (33.1)	310 (24.2)	546 (42.7)	

* Items were reversed in the scale

Table 38: Propensity to Leave

Do you agree/disagree with each of the following statements?	Strongly disagree/ Disagree N (%)	Neither agree/ Disagree N (%)	Strongly agree/ Agree N (%)	Scale Properties
If I were completely free to choose, I would prefer to continue working at this agency *	119 (9.2)	217 (16.9)	951 (73.9)	N=1311 Mean: 6.8 SD: 2.23 Range: 3-15 Alpha: 0.75
I would like to stay at this agency for a long time *	129 (10.0)	300 (23.3)	861 (66.7)	
If I had to quit work for a while, I would be likely to return to this agency *	144 (11.2)	267 (20.8)	874 (68.0)	

* All items were reversed

9. DETERMINANTS OF PHYSICAL AND MENTAL HEALTH

In this chapter, we focus on the determinants of physical health (diagnosed health problems, work-related injuries and MSDs) and mental health (work-related stress, symptoms of stress scale, emotional exhaustion, depersonalization, personal accomplishment, self-esteem and mastery). The first section looks at the impact of trends in home care since 1997 and investigates associations between these trends and our measures of health as reported by long-term care employees (respondents who had been employed in the home care field prior to 1997 (N=822)). The second section includes the total sample of home care workers (N=1311) and looks more broadly at the associations between organizational change and restructuring, physical factors, psychosocial factors, occupation and individual factors on our measures of health.

9 a) Impact of Health Care Restructuring on Physical Health Measures for Long-term Home Care Workers

As shown in Chapter 7, we developed seven measures to gauge the impact of organizational change and restructuring since 1997 (prior to the introduction of the CCAC). These include a shift to a business focus, individual effects of a shift to a business focus, work intensification, lack of resources, staff shortages, greater client acuity, and poorer quality of care.

Table 39 shows the correlations between these seven measures and diagnosed, back problems, diagnosed work-related MSDs, diagnosed carpal tunnel syndrome, the MSD scale, and work-related injuries for long-term home care workers. The data show that the shift to a business focus has a positive association with diagnosed work-related MSDs, and the MSD scale. Individual effects of this shift to a business focus are positively associated with diagnosed back problems, diagnosed work-related MSDs, the MSD scale and work-related injuries. Work intensification, lack of resources, staff shortages, and greater client acuity all have positive associations with diagnosed work-related MSDs and the MSD scale. Further, the decrease in quality of care to clients is associated with a greater number of MSDs.

9 b) Impact of Health Care Restructuring on Mental Health Measures for Long-term Home Care Workers

Table 40 shows the correlations between these seven measures and job stress, symptoms of stress scale, the three burnout measures (emotional exhaustion, depersonalization and personal accomplishment) and the psychological resources measures self-esteem and mastery.

The shift to a business focus, including the individual effects of this shift, increases stress and burnout as measured by symptoms of job stress, stress scale, emotional exhaustion, and depersonalization. It also decreases personal accomplishment and mastery or control over the environment. Work intensification, lack of resources, staff shortages, greater client acuity and decreased quality of home care are all associated with higher levels of job stress, symptoms of stress, emotional exhaustion and depersonalization. Staff shortages and decreased quality of care lead to fewer feelings of personal accomplishment and less mastery. However, self-esteem is positively associated with work intensification, lack of resources and greater client acuity, perhaps reflecting the self-esteem that comes through accomplishing a job under difficult working conditions.

Table 39: Impact of Organizational Change and Restructuring since 1997 on Physical Health of Long-term Home Care Workers

Factors Affecting Health Problems	Diagnosed Back-problems	Diagnosed work-related MSDs	Diagnosed carpal tunnel	MSD scale	Work-related injuries
Compared to 1997 there has been:					
Shift to Business focus	.059	.143 **	.038	.176 **	.069 *
Individual effects of shift to business focus	.085 *	.126 **	.021	.147 **	.139 **
Work Intensification	.072 *	.093 **	.020	.096 **	.061
Lack of Resources	.061	.119 **	.063	.116 **	.056
Staff Shortages	.049	.122 **	-.010	.151 **	.083 *
Greater Client Acuity	.064	.132 **	-.004	.099 **	.052
Decreased Quality of Care	.012	.067	.067	.154 **	.061

N=822   * $p < .05$ ** $p < .01$

Table 40: Impact of Organizational Change and Restructuring since 1997 on the Mental Health of Long-term Home Care Workers

Factors Affecting Health Problems	Job stress	Stress scale	Emotional Exhaustion	Depersonalization	Personal Accomplishment	Self-esteem	Mastery
Compared to 1997 there has been:							
Shift to Business focus	.374 **	.330 **	.362 **	.283 **	-.047 **	.043	-.118 **
Individual effects of shift to business focus	.298 **	.344 **	.365 **	.229 **	-.113 **	-.026	-.173 **
Work Intensification	.374 **	.267 **	.330 **	.177 **	.081 *	.096 **	-.037
Lack of Resources	.283 **	.203 **	.216 **	.124 **	.133 **	.111 **	.019
Staff Shortages	.279 **	.248 **	.248 **	.148 **	-.129 **	.008	-.075 *
Greater Client Acuity	.267 **	.179 **	.222 **	.150 **	.082 *	.136 **	.017
Decreased Quality of Care	.176 **	.247 **	.255 **	.233**	-.120 **	-.002	-.102 **

N=822 * p < .05 ** p < .01

9 c) Measures of Determinants of Health

Guided by our previous research, the literature review and the results of the key informant interviews and focus groups, we developed a series of statements that might be used to describe home care jobs, the home care environment, the organization, supervision, co-workers and clients receiving care. All survey respondents were asked if they disagreed or agreed with each statement on a 5 point Likert scale that ranged from strongly disagree to strongly agree. Following our conceptual model, we developed a number of measures to estimate the impact of organizational change and restructuring, physical working conditions, psychosocial working conditions, occupation, and individual characteristics on health. Most of these measures are summative scales and the distribution of responses to each scale item and the characteristics of the scale itself (mean, standard deviation, range and Chronbach's alpha as a measure of scale reliability) are found in Appendix A.

Measures of **Organizational Change and Restructuring** include a business focus scale (5 items), a workload intensification scale (5 items), a lack of resources scale (4 items), a staff shortage scale (6 items), a client acuity scale (3 items), a wage inequalities scale (2 items), an organizational change scale (5 items), concern with budget cutbacks scale (3 items), fear of job loss scale (2 items) and a workload/job intensification scale (7 items).

Measures of **Physical Working Conditions** include a measure of job requires physical effort, a physical office environment scale (3 items), a measure of working an extended day (or compressed work week), a safety hazards in clients' homes scale (5 items), a measure of the repetitious nature of the job, a measure of whether the respondent had been a victim of crime on the job and a measure of having no time to travel between clients. Also included in the analysis of physical health is a measure of work injury during the past year and whether the respondent had been injured moving clients.

Measures of **Psychosocial Working Conditions** include an organizational support scale (9 items), peer support scale (4 items), control over work scale (4 items), emotional labour scale (7 items) no time for support to clients (2 items), enjoy working with clients one-one-one scale (2 items), client take advantage scale (7 items) and questions that asked whether they receive adequate information from their supervisor regarding difficult clients, and measures of whether they had been exposed to inappropriate racial/ethnic or sexual comments or behaviour by clients or client family members. The symptoms of stress scale were also included as a predictor of physical health problems.

Occupation is measured as a set of dichotomous variables. **Individual characteristics** include months in profession, age, gender, and years of schooling, married versus other, children in the household and a measure of primary income earner.

In the quantitative analysis we examine the zero-order Pearson Correlation Coefficients (r) between the measures of health and the measures of organizational change, physical working conditions, psychosocial working conditions, occupation and individual characteristics. Multivariate analysis of these determinants of health will be presented in further analysis of the data and will be published in journal articles.

9 d) Determinants of Physical Health

Organizational change and restructuring has an impact on the physical health of home care workers. Although the associations are not strong, they are significant and consistent as shown in Table 41. In particular, business focus, workload intensification, lack of resources, staff shortages, client acuity, wage inequalities, organizational change, concerns with budget cutbacks, fear of job loss and heavy workload are all positively associated with diagnosed MSDs and the MSD scale. In addition, respondents with higher scores on business focus, lack of resources, staff shortages, wage inequalities, organizational change, concerns with budget cutbacks, fear of job loss and heavy workload are more likely to have a work-related injury.

The physical nature of home care work affects the physical health of home care workers and increases the likelihood of a work-related injury. Higher scores on job requires physical effort, safety hazards in clients' homes, being a victim of crime on the job, having no time to travel between clients, homes are associated with higher scores on diagnosed health problems and the MSD scale. Work related injuries is positively associated with job requires physical effort, safety hazards in clients' homes, having a job that is repetitive, and having no time to travel between clients. Furthermore, respondents who had an injury while moving clients are more likely to have a work-related injury.

Psychosocial factors are also associated with the physical health of home care workers. Respondents with higher scores on organizational support are less likely to have a diagnosed health problem, MSDs or a work-related injury. Peer support also decreases the likelihood of MSDs and work-related injuries. Other factors associated with MSDs include having little control over work, working with difficult clients, providing emotional care, having no time for client emotional support, not receiving adequate information on difficult clients, being exposed to inappropriate ethnic comments or sexual comments or behaviour and having clients take advantage. Work-related injuries are more likely if respondents work one-on-one with clients, have no time for client emotional support, work with clients who take advantage, and if respondents are exposed to inappropriate ethnic or sexual comments or behaviour.

We also looked at the effect of stress on physical health problems. The data show positive associations between stress and diagnosed health problems, MSDs and work-related injuries.

Looking at occupation, nurses are more likely than other home care workers to have diagnosed back problems and diagnosed MSDs. Home support workers are more likely than other home care workers to have a work-related injury. Therapists and supervisors are less likely to have work-related injuries.

Finally, the number of months in their profession and age are all associated with diagnosed health problems and MSDs.

Table 41: Associations with Physical Health

Factors Affecting Health Problems	Diagnosed Back Problems	Diagnosed MSDs	Diagnosed carpal tunnel	MSD scale	Work-related injuries
ORGANIZATIONAL CHANGE & RESTRUCTURING					
Business Focus	.068 *	.123 **	.063 *	.134 **	.083 **
Workload Intensification	.065 *	.102 **	.008	.055 *	.021
Lack of Resources	.059 *	.102 **	.073 **	.103 **	.076 *
Staff Shortages	.074 **	.140 **	.037	.176 **	.145 **
Client Acuity	.034	.109 **	.059 *	.105 **	.047
Wage Inequities	.025	.042	.046	.047	.041
Organizational Change	.050	.147 **	.085 **	.185 **	.109 **
Concerns with budget cutbacks	.060 *	.057 *	.083 *	.131 **	.069 *
Fear of job loss	.070 *	.041	.091 **	.126 **	.079 **
Heavy Workload	.080 *	.111 **	.067 *	.220 **	.109 **
PHYSICAL FACTORS					
Job requires physical effort	.088 **	.096 **	.083 **	.134 **	.142 **
Physical office environment	-.010	-.125 **	-.069 *	-.080 **	-.052
Work extended day	.044	-.001	-.026	.025	.045
Safety hazards in clients' homes	.108 **	.115 **	.054	.143 **	.103 **
Job is repetitious	.037	.046	.045	.123 **	.100 **
Victim of crime on job	.037	.061*	.125 **	.082 **	.037
No time to travel between clients	.097 **	.102 **	.038	.175 **	.175 **
Work-related injuries	.229 **	.205 **	.067 *	.304 **	
Injuries moving clients	.327 **	.185 **	.109 **	.293 **	.320 **

Factors Affecting Health Problems	Diagnosed Back Problems	Diagnosed MSDs	Diagnosed carpal tunnel	MSD scale	Work-related injuries
PSYCHOSOCIAL FACTORS					
Organizational support	-.066 *	-.128**	-.069 *	-.116 **	-.096 **
Peer support	-.020	.001	-.022	-.170 **	-.088 **
Control over work	-.049	-.043	-.034	-.136 **	-.078
Emotional labor	.061*	.005	.019	.060 *	.048
Client one on one	-.013	.038	.026	.003	.073 **
Difficult clients	.023	.065 *	-.008	.091 **	.025
No time for client emotional support	.039	.036	.022	.115 **	.074 **
Receive adequate information on difficult clients	-.062 *	-.077 **	.014	-.068 *	-.044
Exposure to Ethnic Comments	.082 **	.129 **	.070 *	.106 **	.156 **
Exposure to sexual comments	.073 *	.115 **	.063 *	.131 **	.160 **
Clients take advantage	.070 *	.018	.014	.174 **	.151 **
Stress	.194 **	.214 **	.125 **	.475 **	.174 **
OCCUPATION					
Managers	-.007	-.056 *	-.018	-.038	-.062 *
Supervisors	-.039	-.041	-.001	-.066 *	-.063 *
Coordinators	-.026	-.040	.018	-.029	-.003
Office staff	-.031	-.044	.020	.019	-.051
Case Managers	-.012	.129 **	.020	.068 *	.007
Nurses	.084 **	.139 **	-.009	-.003	-.020
Therapists	-.030	-.014	.-023	.068 *	-.078 **
Home support workers	.003	-.098 **	-.009	.042	.117 **

Factors Affecting Health Problems	Diagnosed Back Problems	Diagnosed MSDs	Diagnosed carpal tunnel	MSD scale	Work-related injuries
INDIVIDUAL FACTORS					
Months in Profession	.103 **	.137 **	.046	.063 *	-.009
Age	.082 **	.107 **	.076 **	.059 *	.004
Gender	.041	.039	.041	.087 **	.023
Years of schooling	-.007	-.059 *	-.024	-.021	-.019
Married	.008	-.005	-.022	-.027	-.046
Children in home	-.034	-.001	.034	-.020	.015
Major income earner	.007	-.028	.039	-.017	.051

N=1311 * $p < .05$ ** $p < .01$

9 e) Determinants of Mental Health

In this analysis, we examine the associations between the mental health measures and organizational change and restructuring variables, physical characteristics of home care work, psychosocial factors, occupation and individual characteristics.

Health care restructuring and the change to managed competition contributed to a decrease in mental health among home care workers. The associations are stronger than those for physical health and are very consistent as shown in Table 42 for all home care workers. The change to a business focus, work intensification, lack of resources, staff shortages, client acuity, wage inequities, organizational change, concern with budget cuts, fear of job loss and heavy workload all increased job stress, symptoms of stress, emotional exhaustion, and depersonalization. Interestingly, the change to a business focus, work intensification, lack of resources, client acuity, wage inequities, and concern with budget cuts had a positive association with self-esteem, presumably coping under the stress of these changes served to increase respondent's self-esteem. Staff shortages, organizational change and heavy workload decreased mastery and personal accomplishment.

In terms of physical characteristics of home care work, job requiring physical effort had a negative association with job stress and depersonalization but is positively related to personal accomplishment. Similarly, working in an office environment, decreases job stress, symptoms of stress, emotional exhaustion, and depersonalization and it increases mastery and personal accomplishment. Safety hazards in client's homes increases job stress, symptoms of stress, emotional exhaustion, depersonalization, and self esteem. The more repetitive the work, the more likely respondents have more stress, symptoms of emotional exhaustion, depersonalization and lower levels of self-esteem. Being a victim of crime on the job increases job stress, stress symptoms, emotional exhaustion, depersonalization and lowers mastery. Having no time to travel between clients increases job stress, symptoms of stress, emotional exhaustion, depersonalization and lowers mastery.

Psychosocial factors play an important role in the mental health of home care workers. Those who have higher levels of organizational support have lower levels of job stress, symptoms of stress, emotional exhaustion, depersonalization and higher levels of personal accomplishment, self-esteem and mastery. Peer support also contributes to mental health. Those with higher levels of peer support are less likely to be emotionally exhausted, and have higher levels of personal accomplishment, self-esteem and mastery. Control over work contributes to personal accomplishment, self-esteem, and mastery and is also associated with lower levels of job stress, stress symptoms, emotional exhaustion and depersonalization. There are a number of variables associated with working with clients that play a significant role as determinants of mental health. Respondents who work with clients one-on-one have lower levels of depersonalization and higher levels of personal accomplishment, self-esteem and mastery. However, having no time for emotional support to clients , working with difficult clients, not receiving adequate information on difficult clients and having clients take advantage all increase job stress, symptoms of stress, emotional exhaustion and depersonalization and to some extent, lower personal accomplishment, self-esteem and mastery. Being exposed to inappropriate ethnic comments or sexual comments or behavior also increases job stress, symptoms of stress, emotional exhaustion, and depersonalization.

Some home care occupations are more likely to have higher levels of mental health problems as noted in the earlier analysis. Managers have higher levels of job stress, but fewer symptoms of stress than other home care workers. They also have higher levels of self-esteem, mastery, and personal accomplishment. Compared to other home care workers, supervisors have more job stress and also symptoms of stress, and higher levels of depersonalization. Coordinators too, have higher levels of job stress, symptoms of stress, emotional exhaustion, and depersonalization. Compared to all other home care occupational groups, case managers have the highest levels of job stress, symptoms of stress, emotional exhaustion, depersonalization and they have lower levels of personal accomplishment. Nurses and home support workers are more likely to have lower levels of depersonalization on the job. Home support workers have less stress or burnout than other home care workers, although they also have less self-esteem and mastery.

In terms of individual factors, more experienced home care workers and those with more education have more job stress, symptoms of stress and emotional exhaustion. Other factors associated with stress include having children in the home and being a major income earner.

Table 42: Associations with Mental Health Measures

Factors Affecting Health Problems	Job stress	Stress scale	Emotional Exhaus-tion	Deperson alization	Self-Esteem	Mastery	Personal Accom-Plish-ment
ORGANIZATIONAL CHANGE & RESTRUCTURING							
Business Focus	.332 **	.240 **	.323 **	.214 **	.126 **	.011	-.019
Work Intensification	.377 **	.110 **	.213 **	.040	.176 **	.072 **	.126 **
Lack of Resources	.239 **	.195 **	.218 **	.094 **	.113 **	.017	.064 **
Staff Shortages	.345 **	.354 **	.392 **	.225 **	.016	-.117 **	-.122 **
Client Acuity	.332 **	.219 **	.266 **	.147 **	.099 **	.038	-.011
Wage Inequities	.123 **	.069 *	.102 **	.025	.095 **	.047	.079 **
Organizational Change	.329 **	.357 **	.397 **	.278 **	.000	-.177 **	-.170 **
Concerns with budget cutbacks	.199 **	.166 **	.212 **	.092 **	.052	-.013	.007
Fear of job loss	.227 **	.190 **	.222 **	.114 **	.025	-.108 **	.050
Heavy workload	.547 **	.396 **	.554 **	.250 **	.079 **	-.139 **	-.071 *
PHYSICAL FACTORS							
Job requires physical effort	-.088 **	-.027	-.009	-.103 **	.025	-.040	.152 **
Physical office environment	-.168 **	-.185 **	-.225 **	-.146 **	-.006	.061 *	.067 *
Work extended day	.013	.004	.053	.041	-.019	-.028	.054
Safety hazards in clients' homes	.296 **	.193 **	.263 **	.091 *	.074 **	-.035	-.015
Job is repetitious	-.048	.122**	.103*	.089*	-.080	-.111 **	-.089 **
Victim of crime on job	.134 **	.141 **	.167**	.107 **	-.043	-.133 **	-.014
No time to travel between clients	.179 **	.232 **	.260 **	.116 **	-.030	-.150 **	-.056

Factors Affecting Health Problems	Job stress	Stress scale	Emotional Exhaus-tion	Deperson-alization	Self-Esteem	Mastery	Personal Accom-Plish-ment
PSYCHOSOCIAL FACTORS							
Organizational support	-.238 **	-.323 **	-.333 **	-.230 **	.077 **	.173 **	.207 **
Peer support	.056 *	-.091	-.075 **	-.019	.167 **	.148 **	.126 **
Control over work	-.125 **	-.224 **	-.217 **	-.142 **	.146 **	.205 **	.259 **
Emotional labour	.009	-.014	-.035	-.147**	.152**	.119 **	.359**
Client one on one	.062 *	-.013	-.034	-.104 **	.167 **	.129 **	.286 **
Difficult clients	.368 **	.203 **	.263 **	.168 **	.100 **	.007	-.031
No time for client emotional support	.243 **	.229 **	.274 **	.145 **	-.030	-.155 **	-.107 **
Receive adequate information on difficult clients	-.208 **	-.193 **	-.182 **	-.102**	-.009	.012	.067 *
Exposure to Ethnic Comments	.128 **	.105 **	.135 **	.107 **	.030	.001	-.009
Exposure to sexual comments	.120 **	.132 **	.182 **	.064 *	.009	-.009	.067 *
Clients take advantage	.156 **	.244 **	.280 **	.213 **	-.083 **	-.218 **	-.151**
OCCUPATION							
Managers	.132 **	-.065 *	.018	-.010	.111 **	.065*	.074 **
Supervisors	.056 *	.055 *	.050	.075 **	.015	.042	-.011
Coordinators	.109 **	.075 **	.074 **	.103 **	.059 *	.000	-.028
Office staff	.006	.059 *	.012	.036	-.003	-.012	-.112 **
Case Managers	.248 **	.186 **	.183 **	.190 **	.064 *	.033	-.067 *
Nurses	.062	-.018	-.024	-.127 **	.030	.038	-.068 *
Therapists	.074 **	-.014	.021	.010	.009	.068 *	.014
Home Support Workers	-.304 **	-.126 **	-.132 **	-.077 **	-.110 **	-.104 **	.024

Factors Affecting Health Problems	Job stress	Stress scale	Emotional Exhaus-tion	Deperson-alization	Self-Esteem	Mastery	Personal Accom-Plish-ment
INDIVIDUAL FACTORS							
Months in Profession	.206 **	.078 **	.091 **	-.033	.078 **	.010	.024
Age	.020	-.067 *	-.057 *	-.121 **	.054	-.037	.054
Gender	.084	-.079 **	.042	-.004	.011	.012	.017
Years of schooling	.198 **	.103 **	.178 **	.112 **	.118 **	.062 *	-.004
Children in the home	.044	.042	.008	.006	-.007	-.005	-.015
Married	.005	.011	.016	-.030	.014	.045	.030
Major Income Earner	.106**	-.027	.033	.059 *	.063 *	-.004	.013

N=1311 * p < .05 ** p < .01

10. DETERMINANTS OF INDIVIDUAL AND ORGANIZATIONAL OUTCOMES

The measures of individual outcomes in the conceptual model include overall job satisfaction, the intrinsic job satisfaction scale and the extrinsic job satisfaction scale. Organizational outcomes include absenteeism, job insecurity and propensity to leave.

10 a) Impact of Organizational Change and Restructuring since 1997 on Individual and Organizational Outcome Factors

As previously discussed, we asked respondents who had worked in the home care field before or during 1997 (before the introduction of managed competition) about their perception of change between 1997 and 2002. This series of questions were used to develop seven measures to gauge the impact of organizational change and restructuring on the home care system and on long-term home care workers. These include a shift to a business focus, individual effects of the shift to a business focus, work intensification, lack of resources, staff shortages, greater client acuity, and poorer quality of care.

Respondents agreeing that since 1997 there had been a shift to a business focus (including the individual effects of this shift) have less overall job satisfaction including both extrinsic and intrinsic job satisfaction, higher absenteeism, higher levels of job insecurity and a greater propensity to leave their organization. Higher levels of work intensification, is associated with lower levels of overall and extrinsic job satisfaction and higher levels of job insecurity. Too, long-term employees noting a growing lack of resources since 1997 were more likely to have less overall job satisfaction and higher levels of job insecurity. Observance to an increase in staff shortages is also associated with lower job satisfaction, higher absenteeism, higher levels of job insecurity, and higher propensity to leave. Observance of greater client acuity is associated with lower levels of job satisfaction and higher levels of job insecurity. Respondents noting a decreasing in the quality of client care have less job satisfaction, higher absenteeism, more job insecurity and a greater propensity to leave the agency.

Table 43: Impact of Organizational Change and Restructuring since 1997 on Individual and Organizational Outcome Factors

Factors Affecting Health Problems	Overall Job Satisfaction	Extrinsic Job Satisfaction	Intrinsic Job Satisfaction	Absenteeism	Job Insecurity	Propensity to Leave
Compared to 1997 there has been:						
Shift to Business focus	-.283 **	-.167 **	-.067 **	.093 **	.370 **	.095 **
Individual effects of shift to business focus	-.377 **	-.374 **	-.183 **	.130 **	.472 **	.165 **
Work Intensification	-.168 **	-.174 **	.041	.016	.209 **	-.048
Lack of Resources	-.090 *	-.147 **	.152 **	.008	.161 **	-.058
Staff Shortages	-.144 **	-.112 **	-.115 **	.094 **	.161 **	.147 **
Greater Client Acuity	-.050	-.076 *	.083 *	.017	.168 **	-.060
Decreased Quality of Care	-.291 **	-.167 **	-.128 **	.093 **	.287 **	.129 **

N=822 * $p < .05$ ** $p < .01$

10 b) Determinants of Individual and Organizational Outcome Factors

In this final section, we return to an analysis of the full sample of home care workers and examine the association between individual and organizational outcome factors and organizational change and restructuring variables, physical characteristics of home care work, psychosocial factors and individual factors. We also examine the relationship between individual and organizational outcome factors and mental and physical health.

Changes due to health care restructuring have an impact on individual and organizational outcome factors. These changes including the shift to a business focus, work intensification, staff shortages, client acuity, and wage inequities are associated with decreased job satisfaction, especially extrinsic job satisfaction. Further, they are also positively correlated to job insecurity. Respondents who agree that there is a business focus and staff shortages have a higher propensity to leave. Too much organizational change is strongly associated with less job satisfaction, both intrinsic and extrinsic, job insecurity and propensity to leave. Concerns with budget cuts, fear of job loss and heavy workload also decrease job satisfaction and increase job insecurity.

Associations also exist between individual and organizational outcome factors and the physical characteristics of home care work. Jobs requiring physical effort are negatively related to extrinsic job satisfaction and positively related to intrinsic job satisfaction. This can be interrupted to mean that the visiting home care workers enjoy working with their clients, but are unhappy with their pay and benefits. Respondents whose job requires physical effort also have higher absenteeism. Home care workers who work in an office environment are more satisfied with both the intrinsic and extrinsic aspects of their work than visiting home care workers. They are also less insecure in their jobs and have a lower propensity to leave. Respondents who work an extended day also have less extrinsic job satisfaction and more job insecurity. Safety hazards in clients' homes are negatively associated with overall job satisfaction and extrinsic job satisfaction and also lead to higher levels of job insecurity. The repetitive nature of home care work is negatively associated with job satisfaction and positively associated with propensity to leave. Having no time to travel between clients decreases job satisfaction and increases absenteeism and job insecurity. Being a victim of crime on the job, work related injuries and injuries moving clients all decrease job satisfaction, increase absenteeism, job insecurity and propensity to leave.

There are important associations between psychosocial factors and individual and organizational outcome factors. Organizational support, peer support and control over work increases job satisfaction, decreases absenteeism, job insecurity and propensity to leave. These are fairly strong relationships and have implications for the organization of home care work. Job characteristics associated with working with clients also have implications for outcome factors. Working one-on-one with clients and providing emotional caring to clients increases intrinsic job satisfaction, but having no time to provide emotional support to clients, working with difficult clients, having clients take advantage and not receiving adequate information about difficult clients decreases job satisfaction, increases job insecurity and increases propensity to leave. Being exposed to inappropriate ethnic or sexual comments or behavior is also associated with decreased levels of job satisfaction, increased job insecurity and propensity to leave.

There are important occupational differences. Compared to other home care workers, managers have higher levels of job satisfaction including both intrinsic and extrinsic job satisfaction and less job insecurity. Coordinators and office staff have less intrinsic job satisfaction and higher levels of job insecurity. Case managers have higher levels of extrinsic job satisfaction, but lower levels of intrinsic job satisfaction and a higher propensity to leave than do other home care occupational groups. Nurses have lower levels of extrinsic job satisfaction than other groups. Therapists have higher levels of intrinsic job satisfaction, less propensity to leave, but higher levels of job insecurity.

In terms of individual characteristics, months in profession and years of age are associated with higher levels of intrinsic job satisfaction and propensity to leave.

Table 44: Associations with Individual and Organizational Outcome Factors

Factors Affecting Health Problems	Overall Job Satisfaction	Extrinsic Job Satisfaction	Intrinsic Job Satisfaction	Absentee -ism	Job Insec- urity	Propensity to Leave
ORGANIZATIONAL CHANGE & RESTRUCTURING						
Business Focus	- .187 **	- .207 **	.010	.065 *	.305 **	.035
Work Intensification	-.005	-.005	.277 **	-.008	.124 **	-.180 **
Lack of Resources	-.024	-.162 **	.139 **	.056 *	.171 **	-.089 **
Staff Shortages	-.246 **	-.226 **	-.178 **	.068 *	.244 **	.194 **
Client Acuity	- .103 **	- .116 **	.033	.065 *	.165 **	.004
Wage Inequities	-.035	-.120 **	.026	.013	.054	-.008
Organizational Change	- .353 **	- .282 **	-.241 **	.038	.383 **	.252 **
Concerns with budget cutbacks	-.155 **	-.216 **	.005	.028	.232 **	.016
Fear of job loss	-.151 **	-.294 **	.116 **	.074 **	.473 **	-.167 **
Heavy Workload	-.244 **	-.131 **	-.045	.036	.228 **	.045
PHYSICAL FACTORS						
Job requires physical effort	-.036	-.125 **	.190 **	.083 **	-.001	-.031
Physical office environment	.188 **	.194 **	.174 **	-.028	-.206 **	-.115 **
Work extended day	.024	-.110 **	.046	.000	.086 **	-.028

Factors Affecting Health Problems	Overall Job Satisfaction	Extrinsic Job Satisfaction	Intrinsic Job Satisfaction	Absentee -ism	Job Insec- urity	Propensity to Leave
Safety hazards in clients' homes	-.146 **	-.210 **	.001	.070 *	.256 **	-.005
Job is repetitious	-.078 **	-.085 **	-.162 **	.048	.047	.109 **
Victim of crime on job	-.122 **	-.070 *	-.053	-.018	.131 **	.050
No time to travel between clients	-.174 **	-.235 **	-.017	.094 **	.248 **	.040
Work-related injuries	-.120 **	-.088 **	-.071 *	.178 **	.109 **	.078 **
Injuries moving clients	-.191 **	-.129 **	-.106 **	.126 **	.165 **	.143 **
PSYCHOSOCIAL FACTORS						
Organizational Support	.391**	.361**	.376**	-.040	-.392**	-.371**
Peer support	.240**	.267 **	.246 **	-.069 *	-.114 **	-.255 **
Control over work	.330**	.293 **	.436 **	-.049	-.266 **	-.266 **
Emotional labour	.103**	-.095 **	.360 **	.011	-.053	-.177**
Client one on one	.088**	-.057 *	.322 **	.032	-.023	-.143 **
Difficult clients	-.153**	-.146 **	-.046	.032	.166 **	.034
No time for client emotional support	-.187**	-.221 **	-.127 **	.022	.176 **	.056*
Receive adequate information on difficult clients	.226**	.235 **	.158 **	.025	-.229 **	-.188 **
Exposure to Ethnic Comments	-.160**	-.166 **	-.049	.044	.123 **	.075 **
Exposure to sexual comments	-.119**	-.176 **	-.030	.040	.127 **	.047
Clients take advantage	-.218**	.-.198 **	-.151 **	.104 **	.197 **	.165 **
Stress symptoms	-.331**	-.211**	-.306**	.085**	.354**	.181**
OCCUPATION						
Managers	.084**	.109 **	.090 **	-.021	-.101 **	-.016
Supervisors	.021	.006	-.049	.025	.026	.004
Coordinators	-.030	-.022	-.073 **	-.008	.090 **	-.001

Factors Affecting Health Problems	Overall Job Satisfaction	Extrinsic Job Satisfaction	Intrinsic Job Satisfaction	Absentee-ism	Job Insec-urity	Propensity to Leave
Office Staff	.047	.044	-.079 **	-.001	.061 *	-.024
Nurses	-.013	-.143 **	.066 *	.015	.072 **	-.041
Case Managers	-.094 **	.113 **	-.106 **	-.011	-.044	.103 **
Therapists	.051	.017	.087 **	-.058 *	.088 **	-.103 **
Home Support Workers	-.010	-.005	.023	.019	-.120 **	.042
INDIVIDUAL FACTORS						
Months in Profession	-.045	-.042	.082 **	.033	.080 **	-.108 **
Age	.036	-.043	.160 **	.041	-.023	-.155 **
Gender	-.043	-.021	-.034	.024	.066 *	-.002
Children in the Home	.002	-.044	-.035	-.019	.074 **	-.020
Marital Status	-.029	-.003	-.005	-.075 **	-.017	-.042
Major Income Earner	.027	.013	.090 **	.010	.011	-.004
Years of schooling	-.058 *	.000	-.058 *	-.042	.056 *	.076 **

N=1311 * $p < .05$ ** $p < .01$

The mental and physical health of home care workers impacts both the individual and outcome organizational factors measured in this study as shown in Table 45.. Higher levels of job stress and stress symptoms, emotional exhaustion and depersonalization decrease job satisfaction, both intrinsic and extrinsic, increase job insecurity and decrease propensity to leave. Higher levels of personal accomplishment, contribute to job satisfaction and decrease job insecurity and propensity to leave. Psychological resources such as self-esteem and mastery increase job satisfaction decrease job insecurity and propensity to leave. In terms of physical health, in general, diagnosed health problems, MSDs and work-related injuries all decrease job satisfaction, especially extrinsic job satisfaction, increase absenteeism, job insecurity and propensity to leave.

Table 45: Associations of Individual and Outcome Organizational Factors with Mental and Physical Health

HEALTH	Overall Job Satisfaction	Extrinsic Job Satisfaction	Intrinsic Job Satisfaction	Absentee-ism	Job Insecurity	Propensity to Leave
MENTAL HEALTH						
Job Stress	-.280**	-.147 *	-.097 **	.017	.279 **	.102 **
Stress Scale	-.331 **	-.211 **	-.306 **	.085 **	.354 **	.181 **
Emotional exhaustion	-.404 **	-.253 **	-.290 **	.033	.383 **	.220 **
Depersonalization	-.244 **	-.071 *	-.259 **	-.006	.227 **	.180 **
Personal Accomplishment	.242 **	.048	.451 **	.010	-.221 **	-.262 **
Self-esteem	.115 **	.064 *	.246 **	.005	-.098 **	-.130 **
Mastery	.200 **	.111 **	.206 **	-.038	-.266 **	-.107 **
PHYSICAL HEALTH						
Diagnosed Back Problems	-.060 *	-.112 **	-.025	.086 **	.084 **	.012
Diagnosed work-related MSDs	-.095 **	-.104 **	-.033	.060 *	.115 **	.069 *
Diagnosed Carpal Tunnel	-.031	-.050	.024	.148 **	.049	.030
MSD scale	-.161 **	-.159 **	-.095 **	.184 **	.184 **	.087 **
Work-related injuries	-.120 **	-.088 **	-.071 *	.178 **	.109 **	.078 **

N=1311 * p < .05 ** p < .01

11. HEALTH PROMOTION

11 a) Health Promotion

Lastly, we were interested to know what the Home Care Agencies were doing to promote healthy work environments. Respondents were presented with a list of work place health promotion activities and events that their agencies may provide or make available to employees.

Table 46: Health Promotion

What is your agency doing to promote workplace health? Does your agency have/provide:	Yes N (%)	No N (%)
A Health and Safety Committee	1078 (84.5)	198 (15.5)
General training sessions	825 (64.7)	451 (35.3)
Pamphlets/Brochures	881 (69.0)	395 (31.0)
Immunization (flu shot, Hepatitis B etc.)	810 (63.5)	466 (36.5)
An Employee Assistance Program (EAP)	608 (47.7)	667 (52.3)
Work programs for injured workers	402 (31.6)	871 (68.4)
Voice mail tutorials	425 (33.3)	851 (66.7)
Washing or sterilization of equipment	235 (18.4)	1040 (81.6)
Training or ergonomic adjustments in the clients homes or in the office	495 (38.8)	780 (61.2)
Stress leaves	305 (23.9)	969 (76.1)
Protective equipment (i.e. gloves, masks)	900 (70.6)	375 (29.4)
A supportive environment	559 (43.8)	716 (56.2)
TB testing	294 (23.1)	981 (76.9)
Information of client’s health diagnosis	745 (58.4)	530 (41.6)
Employee recognition or events	780 (61.2)	495 (38.8)
Electronic equipment (cell phones, pagers)	445 (34.9)	831 (65.1)
Other health promotion activities/events	155 (12.2)	1118 (87.8)

N=1311

At the time of the survey, most respondents (85%) believed that their agencies had Health and Safety Committees and that protective equipment such as masks and gloves were available to them. Most employees also believed that pamphlets and brochures were available in agencies and that their agencies provided general training sessions and immunization programs such as Hepatitis B and flu shots. Many agencies (61.2%) hold employee recognition events. However, fewer agencies provided TB testing, stress leaves and work programs for injured workers.

Employees were asked how effective their agencies were in promoting the health of its employees. Approximately 85% of all respondents believed that their agencies were somewhat effective to very effective in promoting health, while 15% of respondents felt that their agencies were not effective in promoting health.

Table 47: Agency Effectiveness in Promoting Health

How effective is your agency in promoting the health of its employees?	N (%)
Not at all effective	42 (3.3)
Not very effective	154 (12.1)
Somewhat effective	429 (33.8)
Effective	505 (39.8)
Very effective	138 (10.9)
Total	1268 (100)

N=1311

12. CONCLUSIONS AND DISCUSSION

In this study we examined the impact of health care restructuring and other organizational changes on the mental and physical health of home care workers. We also considered the impact of a variety of physical, psychosocial, and individual factors in our analysis. In this report, we provide descriptive statistics and significant associations between variables. Multivariate analyses to determine associations between variables while controlling for other variables will be conducted at a later stage.

This report is based on qualitative and quantitative data collected from key decision-makers of management and union leaders and employees in 11 agencies. To collect data we conducted interviews, focus groups and surveys. This triangulation of data showed consistent findings on workers' health, factors affecting health and individual and organizational outcomes. In many aspects the health and work-life issues were similar for large and small agencies, for-profit and not-for-profit agencies, and unionized and non-unionized agencies. The most significant factor affecting the home care agencies and the work environment were organizational change and health care restructuring factors. In this section we first discuss workplace illnesses and injuries. Then we examine how the changes in the health care sector affect the health of home care workers. Lastly we discuss factors affecting workers' mental and physical health and individual and organizational outcomes.

12a) Physical and Mental Health

Work related stress was the major health concern mentioned most frequently by interview and focus group participants. Both managers and union leaders were quick to acknowledge stress on the job and its effects on organizations and the mental and physical health of individuals. We should remind the readers that the stress experienced by workers is not caused by a single incident but is a result of an increasingly deteriorating work environment. More than a quarter of survey respondents reported their job as stressful or very stressful. About a quarter of respondents also said that overall, their lives were stressful or very stressful. The most common symptoms of stress in the respondents were being exhausted at the end of the day, not feeling energized on the job, and not being able to sleep through the night.

While job stress, stress in life and symptoms of stress seem to be significant health problems for all home care workers, there were some differences between occupations. Case managers, coordinators and supervisors showed more symptoms of stress than the others. Stress was negatively affecting their health, particularly in the form of burnout. Managers, on the other hand, showed high levels of job stress, but they did not seem to report symptoms of burnout. Instead, the work-related stress experienced by managers resulted in more positive feelings of personal accomplishment on the job. We suspect that these occupational differences are related to the control-over-work and control-over-the-workplace factors which will be analyzed at a later date.

Focus group and interview participants described **burnout** due to excessive work stress as another serious health problem. Burnout was measured as three components in the survey: emotional exhaustion; depersonalization and feelings of personal accomplishment. Survey results showed moderate degrees of emotional exhaustion, low degrees of depersonalization and relatively high degrees of personal accomplishment for all workers. However, case managers, coordinators and supervisors showed the highest level of emotional exhaustion and depersonalization of the job. On the positive side, workers in all occupations showed a high degree of personal accomplishment from their work. These results, in conjunction with the findings from the stress scale, suggest that case managers, supervisors and coordinators are having serious health problems. This is not surprising as these middle level management workers are pressured from the top (managers) and from the bottom (clients and visiting staff) to accomplish more with less (time, staff and financial) resources. The work situation of workers in these occupations should be a particular concern for decision-makers at all levels since they seem to be the 'at-risk' workers for serious occupational health problems.

On the positive side, workers in all occupational groups in home care sector show high levels of **self-esteem and mastery**. Self-esteem questions reflect the amount of positive feelings an individual holds about her/himself. Mastery measures the extent to which an individual believes that her/his life-chances are under their control. Close to 90% of respondents showed very high levels of self-esteem and about three-quarters showed high levels of mastery. These survey responses were reflected in focus groups and interviews.

In terms of physical health conditions, home care workers included in our study were more likely to have **physical health problems**, such as back pain, rheumatism or arthritis, migraine headaches, high blood pressure, and stomach or intestinal disorders than working women of similar age group in Canada. Work-related injuries are also a serious concern as nearly one-in-ten home care workers were **injured** at work in the last year. Work-related injuries were more common in visiting staff (home support workers, nurses and therapists) and the most common type of injury were sprains or strains. Injuries were most likely the result of repetitive strains, accidental falls and trying to protect the client from falling. Most injuries had taken place inside clients' homes. Back injuries were the most common body part injured, followed by arms and hands, and shoulder and neck.

In interviews and focus groups, physical tiredness, exhaustion and musculoskeletal disorders (**MSDs**) were the most common physical health problems discussed. Some of the injuries discussed above seemed to be associated with MSDs. These are commonly known as repetitive strain injuries, carpal tunnel syndrome, or soft-tissues injuries. MSDs are disorders of the soft tissues and surrounding structures in the back, neck/shoulder, elbow/hand, hips, knees, ankles/feet, or sore/sprained muscles. Our data shows that home care workers show high levels of MSDs. Almost one-in-five reported a diagnosed MSD, and between one-in-five to two-in-five respondents reported MSD symptoms some, most or all of the time. We should note that in self-reporting we asked about specific symptoms of MSDs without naming particular illnesses so that respondents will not be influenced to report specific MSDs. While there are no known data to compare the MSDs in our population of home care workers to the Canadian female working population of the same age group, we do know that back injuries among our respondents are twice the rate in the Canadian population (working women in the same age group). Thus, our study suggests that MSDs may be higher among home care workers. This is an important contribution to growing Canadian research on work-related MSDs.

Results of our study show that **workplace harassment/violence** is an occupational health problem for home care workers. Close to one-in-five survey respondents had experienced violence or threat of violence in their work life, and almost one-in-ten had experienced workplace harassment/violence in the last year. The majority of these were victims of client aggression, mostly in the form of verbal threats. However, many of the respondents reported being the victim of violence in the form of pushing, scratching or pinching, slapping or hitting. Home care workers, primarily visiting staff whose workplace is in the home of the client, also reported sexual harassment and sexual assault. Among the visiting staff, home support workers seem to be the most prone to workplace harassment and violence. Workplace harassment and violence is a serious occupational health and safety problem that must be addressed. At most workplaces, even one case of harassment or violence is considered to be too many, and home care workers are experiencing many.

12b) Restructuring and Organizational Change

Changes in the home care sector since 1997 (the year managed competition started) had a significant impact on the health of workers, the agencies, clients and the services delivered. Respondents in interviews, in focus groups and in the survey reported how the health care and home care sectors were restructured. Since 1997, they described how the service delivery approach and management style has become more **"business-like"**, focusing more on productivity measurements and cost cutting and less on preventive care and service delivery. There is a pressure for continuous improvement in work processes, and more emphasis on accreditation and risk management. There is less cooperation between agencies, and less support from co-workers and managers. Agencies who once worked together are now competing for contracts to deliver home care. The restructuring in the hospital sector has meant that many clients are being released from hospitals quicker and sicker, and the service has to be provided 24 hours a day for 7 days of the week. The care given to home care clients is more complex, many new technologies are being used in the homes of clients, and work designs and processes have changed. Technology is being used more extensively not only for client care but also for communications between staff members. Jobs have changed as more and more work is downloaded. Interview and focus group participants told us that home care nurses are now doing the tasks that were once done in hospitals, home support workers are doing tasks that were once nursing tasks, and families of clients are expected to provide more care.

While home care has undergone dramatic restructuring, home care budgets have not kept pace with the growth in demand for service. There is a severe **lack of resources** in home care. The shortage of resources is not only financial but also in human resources. Staff shortages are also the result of wage inequities with hospital nurses and personal support workers being paid more than their home care counterparts. There is a fluctuation of staff numbers, sometimes workers being laid off and sometimes with unfulfilled worker demand. These fluctuations seem to be adding to the existing staff shortages and high turnover in home care. For example, at the time of the focus groups, agencies were facing staff shortage crises, with schedulers practically “begging” workers to take extra shifts. Employees were working overtime and felt pressured to work more than they wanted. At this time, managers were concentrating on issues of recruitment and retention. Yet, in the few months between our focus groups and our survey, the focus changed to layoffs and cutbacks in hours. This was the result of drastic CCAC budget cuts which reduced the number of home care clients in Hamilton from approximately 11 000 to 7500 (Frketich, 2002). This reduction led to an oversupply of home care workers and layoffs in some agencies. And, since our survey was completed, one agency declared bankruptcy and went out of business.

The restructuring and organizational changes have also resulted in **work intensification** among the workforce. In focus groups and in survey responses, workers were consistently saying that their workload is now heavier in comparison to pre-managed competition days; there is pressure to do more with less time; the skills required to do the job have increased; and the job has become more complex. Many workers are doing unpaid work to finish the tasks of their jobs, and are working in evenings and weekends. Jobs have also become more insecure and while pay has increased in some agencies, many benefits such as pay for travel between clients, have decreased or been taken away. Workers in these agencies are also not happy about the **quality of care** in comparison to pre-managed competition. Many have said that overall, the quality of care in home care sector has decreased, and some have said that the care provided by their agency has also decreased.

In interviews, managers and union representatives were repeating these responses. Managers were particularly concerned with **the problems of managing** in a constantly changing, volatile environment, with perceived staff dissatisfaction and high levels of work-related stress. They were trying to manage with staff shortages and high turnover. Moreover, management and all levels of workers were particularly unhappy with the amount of time and energy spent on extensive request for proposals (RFPs) and the short lengths of contracts awarded. They were distressed that in contract awarding process no attention was being paid to the history of the agency in the community, and no consideration was being given to the close ties they had established in the community. Some also discussed the problems associated with the non-standardization of the RFP process in Ontario with varied and often unknown expectations from the CCACs here in this city and elsewhere. These problems seemed to be creating stress for decision-makers, which trickle down to staff at all levels creating stress, anxiety, persistent unhappiness, physical illnesses, injuries and burnout.

The majority of respondents, i.e., managers, union representatives and workers alike, were **critical of the restructuring and managed competition process**. Over one-half of workers were concerned about losing their jobs because their agencies might lose their contract with the CCAC. As we will present below, these feelings of job insecurity were highly associated with the increased levels of stress and burnout, MSDs, job dissatisfaction, absenteeism, and staff turnover.

12c) Individual And Organizational Outcomes

In this project we focused on **job satisfaction**, **absenteeism rate, job insecurity and the turnover intentions** (i.e. propensity to leave) as outcomes of workplace health problems. Overall, home care workers in this study are satisfied with their jobs and **intrinsic job satisfaction** was very high. In our study, the intrinsic job satisfaction refers to the general feeling of accomplishment from the job, finding the job interesting, and something that they look forward to each morning. **Extrinsic job satisfaction** refers to more financial aspects of the job such as satisfaction with pay and benefits, satisfaction with promotion possibilities, and feelings of job security. Only a small minority of respondents were satisfied with the extrinsic aspects of their jobs. Results of the study also show that the **absenteeism rate** at agencies is fairly high, with an average of seven days of absenteeism per worker in these agencies.

Now turning to job insecurity, there seemed to be a high level of perceived **job insecurity** among home care workers who participated in this study. It is well known that in the home care sector, particularly within the personal (home) support workers group, there is about a third of the workforce in hourly (casual) jobs. In our analysis, job insecurity does not refer to this aspect of the job. Instead, we refer to the perceptions of security with respect to whether their job will continue for the next few months; whether their workplace will be in business after the next RFP process; and whether there will be sufficient funding in the provincial and/or CCAC budgets to continue their employment in home care. Focus group participants discussed how insecurity in the sector is related to the RFP process. Home care workers at all levels reported a fear of losing job due to forces outside of their control (i.e. the RFP process, and government decisions). They were worried about their jobs, their family income, their careers, and their retirement years. The possibility of being out of job and starting elsewhere, losing years of seniority with a present employer, and not having a proper pension in their old age, were concerns of many.

It is interesting that while almost half of the survey respondents reported that they were worried about their job security, they were still loyal to their employing agencies and clients. The **propensity to leave** measure showed that more than two-thirds of the workers were interested in continuing to work with the same employer for a long time and would be interested in returning there if they were to quit their jobs for a while. Again, it is worth noting that in the last six months, one of the non-profit home-making agencies participating in our study went bankrupt and all their employees lost their jobs.

12d) Associations Between Variables: Factors Affecting The Health of Home Care Workers, Individual Outcomes and Organizational Outcomes

At this stage of the discussion, we turn our attention to factors affecting physical and mental health problems and individual and organizational outcomes. In following sections we discuss associations between variables. Our analysis showed that there were a number of **factors associated with increased levels of physical and mental health problems** of workers. For physical health, in this analysis we focus on MSDs and injuries, and for mental health we focus on stress and burnout, followed by individual outcomes of job satisfaction, and organizational outcomes of absenteeism, job insecurity and propensity to leave.

1. Factors Affecting the Physical and Mental Health of Home Care Workers

Organizational Change and Restructuring Factors

First we examine associations between health problems and organizational change and restructuring that took place since 1997 for long-term employees (N=866). We found that organizational change and restructuring were significantly and positively associated with diagnosed work-related MSDs and self-reported MSDs. The relationships of these factors with work-related injuries were somewhat weaker but generally in expected directions, with organizational change and restructuring associated with injuries. Organizational change and restructuring factors were also associated with increased stress and burnout among home care workers. Interestingly, organizational change and restructuring were associated with increased levels of self-esteem among workers. This is perhaps because home care workers took pride in delivering care in spite of a deteriorating work environment. Associations between these factors and mastery, however, suggest that workers were feeling that they were not in control of their lives and work environment.

Next, we examine associations between organizational change and restructuring and health problems for all workers, including both those who had and had not been employed in the home care field before 1997 (N=1311). The analysis of factors affecting physical health showed that the greater the perceived organizational change and restructuring, the higher the physical health problems. Almost all of the organizational change and restructuring factors were significantly associated with diagnosed back problems, MSDs, carpal tunnel, self-reported MSDs and work-related injuries. The business focus, workload intensification, heavy workload, lack of resources, concerns with budget cuts and perceived wage inequities were all factors contributing to diagnosed and self-reported back problems, MSDs and injuries. Staff shortages, client acuity and fear of job loss were also associated with increased levels of these physical health problems.

All organizational change and restructuring variables were significantly associated with mental health problems such as job stress, stress scale, and the emotional exhaustion and depersonalization aspects of burnout. Most were also associated with personal accomplishment, self-esteem and mastery. Overall, these results suggest that perceived organizational change and restructuring in the workplace is associated with higher levels of stress and burnout. At the same time, organizational change and restructuring factors were associated with higher levels of self-esteem. Mastery, however, decreased with staff shortages, heavy workload, and when organizational changes took place. Mastery also declined when home care workers reported being afraid of losing their jobs.

Physical Factors

With the exception of working extended day, all physical factors were significantly associated with the physical health problems, showing that the worse the physical work conditions, the higher the diagnosed and self-reported occupational illnesses and work-related injuries. Similarly, stress was significantly associated with worse physical health problems for home care workers.

With the exception of working extended day, and to some extent job requiring physical effort, all other physical factors were significantly associated with mental health problems. In particular, hazards in the physical office environment and in clients' homes, the repetitiveness of the job, being a victim of crime on the job, and not having enough time to travel between clients were factors significantly associated with increased levels of stress and burnout and decreased self-esteem and mastery.

Psychosocial Factors

Organizational support, and exposure to inappropriate racial/ethnic and sexual comments or behaviour were the psychosocial factors consistently and significantly associated with physical health problems. The analysis suggested that the higher (i.e. better) the perceived organizational (and supervisory) support, the lower the diagnosed back problems, MSDs, carpal tunnel, self-reported MSDs and injuries. The more they experienced racial/ethnic or sexual comments or behaviour, the higher the diagnosed and self-reported physical health problems seemed to be. We should also note that lower perceptions of peer support and control over work, were associated with self-reported MSDs. Self-reported MSDs also seemed to increase as the emotional labour or caring aspect of the job decreased, when there was no time for client emotional support and when workers felt that clients were taking advantage of them. Receiving adequate information on difficult clients contributed to decreased levels of MSDs.

Organizational support, peer support and control over work decreased stress and burnout, and increased self-esteem. Being able to deal with difficult clients was also a positive factor in mental health. Providing emotional care to clients and working with clients one-on-one seemed to improve the self-esteem, mastery and personal accomplishment and lower depersonalization. Receiving adequate information on difficult clients seemed to be similarly important in decreasing stress and burnout. And, lastly, results suggest that exposure to racial/ethnic comments or experienced sexual harassment had no effect on self-esteem and mastery, a small association with the feelings of personal accomplishment, and positive and significant associations with stress and burnout.

Occupation and Individual Factors

Associations were found between physical health problems and some occupations, particularly case managers, nurses, therapists, home support workers and supervisors. Further analysis (multivariate analysis) may suggest more definitive associations. Working as office staff and as coordinators showed no associations with the physical health problems of MSDs and injuries. Among individual factors, the analysis showed that as workers aged and spent more years on their jobs, they were more prone to diagnosed back problems, MSDs, carpal tunnel injuries, MSD symptoms and work-related injuries. Gender played a role only in self-reported injuries, showing that it was mostly women reporting MSDs. As suggested to us in one of our focus groups, this is possibly because female workers might be taking their work experiences more personally, such as worrying about clients, whereas male workers might be able to disassociate themselves from the client once the work is completed. This issue, however, requires further analysis which we intend to conduct at a later stage.

Associations were also found between occupation variables and mental health. While workers in most occupations were stressed, supervisors, coordinators, and especially case managers, seemed to be the most highly stressed, showing symptoms of burnout. Office staff, nurses and therapists showed lesser symptoms of stress and burnout. Associations between these variables deserve further analysis because results suggest that stress might be having a positive effect on managers. We suspect that being a manager is associated with increased levels of self-esteem, mastery, and personal accomplishment perhaps because managers are decision-makers and have more control over the work environment and their own work. Those working as home support workers seem to have lower levels of stress and burnout. In addition, home support workers were the only occupational group significantly showing negative associations with self-esteem and mastery. This may be explained by focus group participants who said that despite their extensive training, they are often not seen or treated as professionals. Among individual factors, most interesting is the association between years of schooling, months in profession and stress and burnout. The associations suggested that the higher the educational level and the longer the tenure in the profession, the higher the stress and burnout.

2. Factors Affecting Individual and Organizational Outcomes

In the last set of our analysis we look at **the determinants of individual and organizational outcomes.** The individual outcomes we examined include job satisfaction, and the organizational outcomes are absenteeism, job insecurity, and the propensity to leave.

Job Satisfaction

Organizational Change and Restructuring Factors

An analysis of the impact of organizational change and restructuring that took place since 1997 shows that almost all of these factors are significantly associated with overall, extrinsic and intrinsic job satisfaction for long-term employees (N=866). Thus, our respondents are saying that when their agencies shift to a business focus rather than a service focus, when they feel less support from managers and coworkers in these volatile and changing work environments, and when they feel insecure in their jobs, their overall job satisfaction and satisfaction with the monetary/security aspects of their jobs decrease significantly. Intrinsic job satisfaction also decreases significantly in restructuring and changing work environments. Only intensification of work did not show any effect on the intrinsic job satisfaction. This is perhaps because their loyalties to their clients and profession is so strong that even if the work is becoming intense and heavier, workers still feel like they are doing their best and feeling good about it. Intensification of work is however, a significant factor decreasing extrinsic job satisfaction and overall job satisfaction. Respondents are thus feeling that they are not adequately compensated for the intense work and heavy workload. Working in an environment of limited resources and being expected to do work previously done by higher skilled workers (and not being compensated for this increased skilled work) also contribute to job dissatisfaction. In addition to these, providing care and service in an environment with greater client acuity, and with fewer staff also affect job dissatisfaction. Lastly, these hard working, dedicated health care workers (from office staff, to managers, to all levels of visiting staff), were perceiving a decline in quality of care given to clients and this is associated with dissatisfaction with their jobs. Part of the decline in quality was pointed out by interview participants who said home care workers had to change clients when they lost or gained home care contracts with the CCAC. Since home care workers identify the relationships with their clients as the most positive aspect of their jobs, it is no wonder that the decline in the quality of care decreases their job satisfaction.

Turning to the responses of all home care workers, organizational change and restructuring factors as well as a few other factors, such as perceived wage inequalities, change in organizations, concerns with budget cuts, fear of job loss, and constant heavy workload, are all contributing to job dissatisfaction. As expected, financial factors of wage inequalities and budget cutbacks are not affecting how workers feel about their accomplishments on the job (i.e. intrinsic job satisfaction).

Physical and Psychosocial Factors

Almost all of the physical and psychosocial work factors are generally associated with job satisfaction. As we would expect, the better the physical work environment (i.e. less safety hazards, sufficient time given to travel between clients), the higher the job satisfaction. Those injured at work, particularly those injured while moving clients, are dissatisfied with their jobs. Stress and burnout are two factors consistently contributing to job dissatisfaction.

On the positive side, the high levels of self-esteem, mastery, and personal accomplishment felt by the respondents in our study increases their intrinsic, extrinsic, and overall job satisfaction. Having a supportive work environment where management and supervisors show their appreciation of the staff's contribution to the success of the workplace, and co-workers showing support, are important for job satisfaction. This suggests that it is not just financial rewards that contribute to job satisfaction. Appreciation by supervisors and co-workers may be all that is needed. The staff in these agencies are caring individuals and seem to prefer working with clients "one-on-one", would like to spend a sufficient amount of time with them, and receive adequate information on difficult clients. When these needs are fulfilled, their job satisfaction increases.

Racial/ethnic/sexist comments and harassment seem to affect extrinsic job satisfaction but not intrinsic job satisfaction. This suggests that respondents may feel they are not being paid enough to deal with insults and harassment. However, despite the harassment, workers feel good about their accomplishments and care they give to clients.

Occupation Factors

The effect of occupation on job satisfaction shows interesting and somewhat expected results. Managers have high job satisfaction and report feeling good about their leadership. On the other hand, coordinators and office staff are not satisfied with the intrinsic aspects of their jobs. Nurses and particularly case managers are the occupations most dissatisfied with their jobs. These two occupational groups are the ones who have the highest pressure on them to perform more with less. Further, nurses are not satisfied with their compensation including pay and benefits. This understandably has resulted in dissatisfaction with their jobs. Although therapists have gone through many changes in their work, especially the change from being permanent staff to self-employed contractors, they are generally satisfied with their jobs. This may be associated with their high pay and more control over their working conditions.

Individual Factors

Individual factors seem to affect intrinsic job satisfaction, but have no association with extrinsic job satisfaction. Tenure on the job, age, and income are associated with increased intrinsic job satisfaction. Having children at home seems to decrease intrinsic job satisfaction, suggesting the dual workload and responsibility contribute to the many workers are feeling today.

Organizational Outcomes

Organizational Change and Restructuring Factors

Results show that all of the organizational change and restructuring since 1997 were positively associated with job insecurity for long-term employees. The shift to business focus, the individual effects of the shift, staff shortages and decreased quality of care were associated with increased absenteeism. Similar association were found between these variables and the propensity to leave. When examining organizational outcomes for all employees, we found that organizational change and restructuring were associated with increased absenteeism, job insecurity and the propensity to leave.

Physical and Psychosocial Factors

Generally speaking, deteriorating physical work factors were significantly associated with absenteeism, job insecurity, and propensity to leave. This was especially the case for work-related injuries and injuries moving clients. With respect to psychosocial factors, peer support, and control over work were associated with decreased absenteeism, job insecurity and the propensity to leave. Symptoms of stress was associated with less job satisfaction (both intrinsic and extrinsic), increased absenteeism, job insecurity and propensity to leave.

Occupation and Individual Factors

In terms of occupation factors, being a manager or a home support worker was negatively associated with job insecurity. This is interesting, as we know that a major home support agency in this study went bankrupt and all the home support workers lost their jobs. Months in profession and age were both positively associated with propensity to leave, suggesting that older workers may be more likely to leave perhaps due to retirement. No individual factors were associated with absenteeism, which indicates that it overwhelmingly work factors which are associated with absenteeism on the job. This presents the possibility that workplaces could reduce absenteeism by addressing workplace issues.

13. RECOMMENDATIONS

Our study suggests a number of changes to improve the working conditions in home care. Improvements in working conditions can prevent occupational illnesses and injuries of home care workers. In this section, we give recommendations to Workplace Safety and Insurance Board to consider implementing. Recommendations provided here also apply to most agencies and union locals partnered in this study. For confidentiality reasons we keep these recommendations generic to all agencies and union locals. Agencies and corresponding unions were given reports specific to their agency so they can use the results to make comparisons with the sector in Hamilton. We hope our recommendations will be implemented so that home care workplaces will be safer and healthier for all workers, and workplace injuries and illnesses in the home care sector will be prevented.

Overall, results of this study suggest that restructuring and organizational changes have negatively impacted the home care agencies. Specifically, restructuring of the sector and organizational change significantly increases work-related stress, burnout and musculoskeletal disorders (MSDs). **We must address some of the key factors in restructuring in order to create a healthy work environment.** A healthy level of stress can result in increased job satisfaction, decreased absenteeism rates and lower intentions to leave the workplace.

Restructuring and Organizational Change

With managed competition, organizations have to compete for contracts to deliver home care in Hamilton. This has resulted in organizations changing to a business-like approach with emphasis on productivity and cost-efficiency and less emphasis on adequate caring of clients. The business focus of management and resultant organizational change were more or less imposed on this workforce by government decisions. These changes are being implemented with the pressures of budget cuts, staff shortages, and increased workloads. Work has intensified, workloads have increased, and there are not sufficient resources in the sector and in the agencies. Workers are concerned with budget cuts. Home care workers are being paid very low in comparison to their counterparts in hospitals and long-term care institutions and many workers do not have benefits. There are fluctuations in staff from shortages to layoffs, making this sector highly volatile. Fluctuations in staff vary with CCAC funding, which varies with the provincial government funding. The restructured work environment has made jobs insecure and is affecting the health of home care workers.

The Impact of Restructuring and Organizational Change

Results of this study show that restructuring and organizational change impacts the health of home care workers in a number of negative ways. First, and foremost, restructuring has resulted in high levels of stress. Restructuring, coupled with stress also contributes to burnout. Burnout can be examined as emotional exhaustion, depersonalization, and feelings of personal accomplishment. Overall the results in our study suggested that the greater the organizational change and restructuring in the workplace, the higher the stress level and the more the burnout cases among the workforce. Restructuring of the sector, organizational change, and stress also tend to increase musculoskeletal disorders (MSDs). This study has also shown that restructuring is associated with increased absenteeism, job insecurity and job dissatisfaction.

13a) Government Policy Recommendations

Work-related stress and other occupational illnesses in the home care sector are preventable. We recommend all stakeholders to take appropriate measures to minimize particularly the negative effects of organizational change and restructuring, to prevent work-related illness among home care workers. Below are a number of policy suggestions to address restructuring.

Recommendation 1: Improve funding in the Home Care Sector

The home care sector in Canada is severely under funded. Home care work has intensified as workers see more clients in less time. Agencies cannot reduce workloads and create healthy work environments without sufficient funding. The provincial government plays a key role in the restructuring and organizational change experienced by these agencies, unions and workers by deciding how the sector should be organized and the budget for each Community Care Access Centre. Since provincial funding is dependent upon transfers from the federal government, the federal government must also play a role in funding the home care sector. The Commission on The Future of Health Care In Canada (Romanow, 2002) has recommended a huge increase in spending on home care in Canada. The Commission also recommends that home care be included in the Canada Health Act in three key areas: home mental health case management and intervention services; home care services for post-acute patients; and palliative home care services. As the demand for home care is rising and patients are released from hospitals quicker and sicker, these recommendations represent steps in the right direction. Our study supports the recommendations outlined in the Romanow Report, but we would move beyond their recommendations to recommend that long-term home care to functionally impaired clients, to enable them to remain at home in the community, also be included in the Canada Health Act.

Recommendation 2: Change How Home Care in Ontario is Delivered

This study indicates that perhaps the government should consider alternative ways of delivering home care in Ontario. Currently home care in Ontario is delivered through a system of Managed Competition, which was implemented in 1997. Many of the home care workers in this study witnessed the transition from a mostly not-for-profit delivery of home care to the system of competition between for-profit and not-for-profit agencies. Interview and focus group participants discussed many of the negative aspects of the new system including: an intensification of work; loss of continuity of care for clients; insecurity; and stress. Our survey results showed associations between restructuring and stress, musculoskeletal disorders, job dissatisfaction, job insecurity and absenteeism. Two-thirds of survey respondents agreed that Managed Competition should be either changed or eliminated. This should be a consideration during the next provincial election in Ontario.

Recommendation 3: Implement Wage Parity with Institutions

Interview, focus group and survey participants were dissatisfied with their pay and benefits. Home care workers in our study overwhelmingly told us that home care workers should be paid the same rate as institution workers with the same level of training. And, key informants told us that this dissatisfaction was contributing to the shortage of workers the industry was experiencing at the time. Wage parity with other health care workers would address the problems of staff shortages and contribute to a more stable work environment for home care workers. This type of change would lead to a more satisfied and healthier workforce.

Recommendation 4: Lengthen Home Care Service Delivery Contracts

Respondents from interviews, focus groups and our survey agreed that the system would improve if home care delivery contracts were longer. Longer contracts would provide more stability and job security for home care workers. It would also reduce the number of RFPs, which have been identified as a huge source of stress for home care workers.

Recommendation 5: Change the RFP process

Focus group and interview participants also told us that they felt that the RFP process should strongly consider the history of each agency and its ties with the community when awarding home care contracts. When managed competition was first implemented, many workers had to leave their clients with whom they had developed close relationships. Interview respondents told us that the RFP process fails to recognize the importance of the relationships that exists between workers and clients. This is an important oversight as results of this study and our previous 1996 study show that the relationships with clients is one of the most positive features of this job and is associated with increased job satisfaction. The home care system should foster these relationships, which could improve client satisfaction as well as morale and job satisfaction for home care workers.

13b) Agency Specific Recommendations

With adequate funding, agencies can begin to create healthy work environments. As discussed above, sufficient and consistent funding for the home care sector would alleviate some of the restructuring and organizational change problems and minimize the stress and burnout for home care workers. Increased funding would allow for adequate levels of staff, reduce heavy workloads, improve job security, and improve pay and benefits for home care workers. All of these would reduce stress and other health problems of home care workers. Creating a healthy work environment, with a healthy level of stress can also benefit agencies by increasing job satisfaction, decreasing absenteeism rates and lowering intentions to leave the workplace. Below are some specific recommendations that could be implemented at the agency level with appropriate funding.

Recommendation 6: Take Precautions To Prevent Burnout Among Occupations Most At Risk

Certain occupations are at-risk for burnout. These are middle-level occupations of case managers, co-ordinators and supervisors. We recommend managers to take precautions to prevent burnout among staff in these occupations. While workers in all occupations showed symptoms of stress, generally case managers, coordinators and supervisors showed higher levels of stress than the others. Examining these results in conjunction with the findings from the stress scale suggest that case managers, supervisors and coordinators, in other words those in middle-level management positions, are having serious health problems. As the personal accomplishment feelings, self-esteem and mastery results showed, these are confident and capable individuals. However, they are pressured from the top, by managers and by the bottom, by clients and visiting staff to do more and accomplish more with less (time, staff and financial) resources. They are in the typical middle management position: with minimal, if any, authority to make changes in the work environment and working conditions, but great responsibility to find and allocate minimal amount of sources to care for the sick, elderly and needy clients. We recommend management in all agencies to pay particular attention to deteriorated working conditions of these occupations and take precautions to improve their work environment, as they are 'at-risk' for serious occupational health problems.

Recommendation 7: Take Precautions To Avoid Work-Related Injuries

Work-related injuries are high, particularly among the visiting staff (home support workers, nurses and therapists). In comparison to the Canadian population of working women of similar age group, home care workers in our study are at a greater risk of having injuries. These work-related injuries are taking place primarily in clients' homes. With adequate funding, we recommend agencies to provide adequate equipment, a second staff person if the caring work is physically hazardous for the workers, improved training for staff, and sufficient time set aside for caring and travelling between clients to avoid accidents and injuries. Workers should be also given the right to refuse work in unhealthy or dangerous environments. We recommend the WSIB to have periodic inspections of the visiting staff's environment to recommend precautions to prevent work-related injuries.

Recommendation 8: Improve Peer and Organizational Support for Home Care Workers

Results of our study indicate that peer and organizational support are associated with decreased levels of stress and other health problems for home care workers. Agencies should make opportunities for home care workers to give and receive support from their peers. This is especially important in the field of home care where work is done in the homes of clients, in isolation from colleagues. Agencies should ask their employees for suggestions to improvements peer support. One example could be mandatory **paid** staff meetings. Again, this would only be possible with improvements in funding. Agency and union sponsored social events may also improve peer relations. And, managers should take appropriate actions to provide support to their staff members. This cannot happen without addressing some of the restructuring issues discussed previously because in a hurried environment, where management is stressed and over-worked, there is little time to talk and provide support to staff members. A simple talk is a very important but often overlooked health promotion action.

Recommendation 9: Take Action to Reduce Harassment and Violence in the Workplace

All workers should be able to perform their jobs in a harassment and violence free work environment. We recommend agencies to work with unions (if unionized) to take precautions to prevent harassment and violence in the work environment, which often originates from the clients. There was a high number of respondents in our study who experienced violence or threat of violence some time during their work life. This seemed to be a hidden epidemic. Most of these were victims of client aggression, in the form of mostly verbal threats. However, pushing, scratching, pinching, slapping, and hitting were also experiences of violence at work for our respondents. Home care workers also experienced sexual harassment and sexual assault. These problems are affecting primarily the visiting staff, particularly personal (home) support workers, whose workplace is the home of the client. Workplace harassment and violence is a serious occupational health and safety problem. In part, it is perpetuated by clients with mental health problems or dementia. We recommend managers and the WSIB to look into resolving these types of hazardous work experiences and start creating harassment- and violence-free work environment for all workers.

13c) Research Recommendations

Recommendation 10: Broaden the Definition of Stress in Work-related Illnesses and Injuries

Results of this study show the complexity of work-related stress and its effects. As such, we recommend a broader definition of stress in work-related illnesses and injuries. Defining stress is a very complex matter and is a continuous debate among experts. Stress is often defined as a reaction of workers to a single, extraordinary event such as shooting in the work environment or seeing the death of co-workers. This narrow definition of stress refers to individuals' reactions to instantaneous and often severe violent actions in the work environment. While acknowledging the importance of these external single events creating stress, we recommend broadening of the definition for coverage under workplace injury and illnesses. We recommend the definition of stress to include individual reactions to continuous and incremental changes in the work environment such as the restructuring of the sector and organizational change.

13d) Conclusion

In conclusion, our results show that occupational health problems experienced by workers in this study are preventable. It is important to acknowledge occupational stress as resulting from incremental changes in the work and external work environment. Stress can result in negative effects on physical health, job dissatisfaction, absenteeism, and propensity to leave the workplace. Overall, sufficient government funding is needed so agencies can begin to create healthier workplaces and healthy workers.

Our results can assist employers, policy makers and workers in preventing work-related diseases and injuries. This research uncovered and provided new information to all stakeholders to improve the prevention of work-related injuries and illnesses. We hope our results can assist the WSIB to improve their policy and process by providing further evidence on how organizational change, restructuring and management policy dictated by the government funding can affect workplaces, work practices and workers' health.

14. IMPLICATIONS AND FURTHER RESEARCH PLANNED

As we conduct further statistical analysis of our data and as our research is published, we anticipate that our findings will make significant contributions to policy formation and professional practices in Canada and elsewhere. We also hope that the results of this project can be used to influence policy formation in home care sector at the local, provincial and international levels. Agencies and unions working with us are anxious to assess the impact of changes made in their organizations, and of health care restructuring on the health and well-being of their employees. We encourage them to use the outcomes of this research to make appropriate work changes that can minimize disabilities and work related illnesses such as stress, burnout and MSDs. Our research contribution will be especially important as home care reform comes to the forefront of policy debates in Ontario and Canada. We also hope that the provincial and national home care organizations will be interested in the study results and will use our results to inform government bodies to develop policies for creating healthier work environments. We also encourage government policy makers to use the results to develop evidence-based policies and reforms in home care sector.

We are also planning to further this study by conducting multivariate analyses of the results, conducting workplace specific (and separately occupation specific) analyses of results. The workplace specific analysis results will be provided confidentially only to the employer and the union representing the workers in that specific agency. Occupation specific analysis results represent all workers in home care sector in Hamilton, and therefore results will be shared more openly. Already our results are suggesting that middle-level managers, i.e. supervisors, co-ordinators and case managers, are ‘at-risk’ occupational groups with significant levels of stress, burnout and resultant physical health problems.

At a later date, we will broaden this study by examining the data for our 1996 respondents. The analysis will include examining a survey that was sent to employees who left their agencies in 1996. Lastly, to have a longitudinal analysis we are planning a study of comparing our 2003 results to 1996 findings. Since our 2003 survey repeated questions from the 1996 survey we will be able to determine if there have been changes in the health and well-being of home care workers. We have already started disseminating the research results in academic conferences and reports prepared for each agency.

APPENDIX A: ADDITIONAL SURVEY TABLES

Table 48: Trends in Home Care Since 1997

To what extent do you agree/disagree with each of the following statements? (1: strongly disagree to 5: strongly agree)	Disagree/ Strongly disagree	Neither agree nor disagree	Agree/ Strongly agree	Scale Properties
Shift to a Business Focus	**N (%)**	**N (%)**	**N (%)**	
Home Care is more "business-like"	76 (9.5)	144 (18.1)	577 (72.4)	Mean: 17.3 SD: 3.12 Range: 5-25 Alpha: .78
There is more emphasis on productivity at your agency	104 (13.2)	231 (29.4)	451 (57.4)	
There is less emphasis on preventive care for clients	280 (35.5)	187 (23.7)	322 (40.8)	
There is less emphasis on care for the whole person	283 (35.8)	136 (17.2)	372 (47.1)	
There is less cooperation between home care agencies	110 (14.0)	347 (44.3)	327 (41.7)	
Individual Effects of Shift to Business Focus				Mean: 9.06 SD: 2.04 Range: 3-15 Alpha:.64
I receive less support from my coworkers	351 (45.0)	249 (31.9)	180 (23.1)	
I receive less support from managers or supervisors	379 (48.0)	169 (21.4)	241 (30.6)	
I have less job security	170 (21.7)	180 (23.0)	434 (55.4)	
Work Intensification				
My workload is heavier	167 (21.4)	127 (16.2)	488 (62.4)	Mean: 21.3 SD: 3.56 Range: 6–30 Alpha: .77
There is pressure to do more with less time	45 (5.7)	65 (8.2)	679 (86.1)	
I work more evenings and week-ends	381 (49.2)	177 (22.8)	217 (28.0)	
The amount of unpaid work I do has increased	288 (36.9)	165 (21.2)	327 (41.9)	
The skills required to do my job have increased	92 (11.7)	118 (15.1)	574 (73.3)	
My job is more complex	99 (12.8)	136 (17.5)	540 (69.7)	
Lack of Resources				
There is a shortage of resources in the home care field	18 (2.3)	59 (7.4)	722 (90.4)	Mean: 17.24 SD: 1.87 Range: 4-20 Alpha: .73
Clients' families are expected to provide more care	23 (2.9)	41 (5.1)	740 (92.0)	
Home care workers now do tasks that were once nursing tasks	41 (5.4)	118 (14.8)	639 (79.9)	
Nurses now do tasks that were once done in hospital	19 (2.3)	99 (12.4)	679 (85.3)	
Staff Shortages				Mean: 10.25 SD: 2.07 Range: 3–15 Alpha: .73
There are more staff shortages at your agency	227 (28.4)	238 (29.8)	335 (41.9)	
There is more staff turnover at your agency	143 (18.1)	257 (32.5)	391 (49.4)	
There are more staff shortages in the home care field	122 (15.3)	197 (24.7)	478 (60.0)	
Greater Client Acuity				
Home care clients are sicker	95 (11.8)	141 (17.6)	567 (70.7)	Mean: 12.45 SD: 1.66 Range: 3–15 Alpha: .72
Some clients are discharged more quickly from the hospital	14 (1.7)	23 (2.9)	770 (95.4)	
The care given to home care clients is more complex	51 (6.4)	98 (12.3)	648 (81.3)	
Decreased Quality of Care				
The quality of home care in general has decreased	172 (21.5)	118 (14.7)	511 (63.8)	Mean: 6.5 SD: 1.66 Range: 2-10 Alpha: .66
The quality of home care delivered by your agency has decreased	343 (43.2)	161 (20.3)	290 (36.5)	Alpha: .66

N=822

Table 49: Business Focus

Do you agree or disagree with each of the following:	Strongly Disagree/ Disagree	Neither agree nor disagree	Strongly agree/ Agree	Scale Properties
Business Focus	**N (%)**	**N (%)**	**N (%)**	Mean: 18.5 SD: 2.98 Range: 5-25 Alpha: .64
Home care is business-like	110 (8.7)	262 (20.8)	887 (70.5)	
There is a big emphasis on productivity at your agency	112 (9.0)	404 (32.4)	730 (58.6)	
There is not enough emphasis on preventative care for clients	152 (12.1)	303 (24.1)	803 (63.8)	
There is not enough emphasis on care for the whole person	126 (10.6)	177 (14.9)	882 (74.4)	
There is poor cooperation between agencies	251 (20.0)	594 (47.3)	411 (32.7)	

N=1311

Table 50: Workload Intensification

Do you agree or disagree with each of the following:	Strongly Disagree/ Disagree	Neither agree nor disagree	Strongly agree/ Agree	Scale Properties
Heavy Workload	**N (%)**	**N (%)**	**N (%)**	Mean: 10.0 SD: 2.45 Range:3-15 Alpha: .62
You work at home in order to complete your work	620 (48.8)	195 (15.4)	455 (35.8)	
Your job requires a high level of skill	134 (11.4)	197 (16.7)	849 (71.9)	
Your job is very complex	259 (20.7)	334 (26.7)	660 (52.7)	

N=1311

Table 51: Lack of Resources

Do you agree or disagree with each of the following:	Strongly Disagree/ Disagree	Neither agree nor disagree	Strongly agree/ Agree	Scale Properties
Lack of Resources	**N (%)**	**N (%)**	**N (%)**	Mean: 16.2 SD: 2.35 Range:4-20 Alpha: .66
There is shortage of resources (money) in the home care field	22 (1.7)	107 (8.4)	1151 (89.9)	
Families of clients are expected to provide too much care	208 (17.4)	241 (20.2)	745 (62.4)	
Home support workers now do tasks that were once nursing tasks	105 (8.9)	197 (16.7)	880 (74.4)	
Nurses do tasks that were once done in hospitals	21 (1.9)	143 (12.6)	967 (85.5)	

N=1311

Table 52: Staff Shortages

Do you agree or disagree with each of the following:	Strongly Disagree/ Disagree	Neither agree nor disagree	Strongly agree/ Agree	Scale Properties
Staff Shortages	**N (%)**	**N (%)**	**N (%)**	Mean: 16.8 SD: 4.93 Range:6-30 Alpha: .82
You feel pressure from your organization to work when you are sick	769 (60.2)	187 (14.6)	321 (25.1)	
You work when you are sick because there is no one available to take over for you while you are not at work	713 (55.7)	196 (15.3)	371 (29.0)	
You feel pressure to work on days off because there are no staff available or others are sick	789 (61.9)	227 (17.8)	259 (20.3)	
You feel pressure to work extra hours or take extra clients when there is a shortage of staff	603 (47.6)	239 (18.8)	426 (33.6)	
Staff shortages are a serious problem at your agency	380 (30.1)	412 (32.6)	472 (37.4)	
Staff turnover (quitting) is a serious problem at your agency	333 (26.6)	474 (37.8)	446 (35.6)	

N=1311

Table 53: Client Acuity

Do you agree or disagree with each of the following:	Strongly Disagree/ Disagree	Neither agree nor disagree	Strongly agree/ Agree	Scale Properties
Client Acuity	**N (%)**	**N (%)**	**N (%)**	Mean: 12.3 SD: 1.83 Range:3-15 Alpha: .63
Some home care clients are too sick to be at home	90 (7.6)	157 (13.3)	931 (79.0)	
Some clients are discharged too quickly from hospitals	21 (1.8)	109 (9.2)	1050 (89.0)	
The care given to some home care clients is very complex	91 (7.7)	190 (16.1)	898 (76.1)	

N=1311

Table 54: Wage Inequalities

Do you agree or disagree with each of the following:	Strongly Disagree/ Disagree	Neither agree nor disagree	Strongly agree/ Agree	Scale Properties
Wage inequalities	**N (%)**	**N (%)**	**N (%)**	Mean: 5.54 SD: .91 Alpha: .81 Range:2-10
There are wage inequalities between similar workers in hospitals and home care agencies	47 (3.7)	160 (12.7)	1055 (83.6)	
There are wage inequalities between similar workers in Long-Term Care Institutions and home care agencies	55 (4.4)	233 (18.6)	967 (77.1)	

N=1311

Table 55: Organizational Change

Do you agree/disagree with the Following statements?	Strongly disagree/disagree N (%)	Neither agree nor disagree N (%)	Agree/ strongly agree N (%)	Scale Properties
Not enough information is given about the future of the organization	362 (28.5)	347 (27.3)	562 (44.2)	Mean: 9.41 SD: 2.55 Range:5-25 Alpha: .70
There have been too many changes in the organization in the past few years	195 (15.3)	377 (29.5)	705 (55.2)	
Managers do not adequately consider the effect of their decisions on staff when initiating new projects	433 (34.8)	454 (36.5)	357 (28.7)	
You spend too much time in meetings	855 (67.6)	289 (22.8)	121 (9.5)	
Your organization does not help you to retain and update your skills	841 (66.1)	206 (16.2)	225 (17.7)	

N=1311 Source: Denton, Zeytinoglu, Davies & Lian, 2002.

Table 56: Concern with Budget Cutbacks

Do you agree/disagree with the following statements?	Strongly disagree/ Disagree N (%)	Neither agree nor disagree N (%)	Strongly agree/ Agree N (%)	Scale Properties
Budget cuts are seriously affecting the quality of the services your organization can provide	70 (5.5)	162 (12.7)	1045 (81.8)	Mean: 8.1 SD: 1.28 Range: 3-15 Alpha: .61
It is difficult to meet the needs of clients with limited resources	71 (5.6)	174 (13.7)	1025 (80.7)	
Too many important decisions about this organization are made by those outside the organization	106 (8.4)	309 (24.4)	851 (67.3)	

N=1311 Source: Denton, Zeytinoglu, Davies & Lian, 2002.

Table 57: Fear of Job Loss

Do you agree/disagree with the following statements?	Strongly disagree/ Disagree N (%)	Neither agree nor disagree N (%)	Strongly agree/agree N (%)	Scale Properties
You are concerned with losing your job due to changes in the long term care sector	372 (29.7)	386 (30.8)	496 (39.6)	Mean:7.2 SD: 1.9 Range: 2-10 Alpha: .59
You are worried that legislation and government policies will affect your job	98 (7.6)	191 (14.9)	993 (77.5)	

N=1311 Source: Denton, Zeytinoglu, Davies & Lian, 2002

Table 58: Workload

To what extent do you agree or disagree with each statement:	Strongly disagree/ Disagree N (%)	Neither agree nor disagree N (%)	Strongly agree/agree N (%)	Scale Properties
The pace of your job is too fast	372 (29.5)	378 (30.0)	512 (40.6)	Mean: 22.6 SD: 5.2 Range: 7-35 Alpha: .86
Your job is too demanding	519 (40.5)	418 (32.7)	343 (26.8)	
You have too much to do on this job	387 (30.5)	426 (33.6)	456 (36.0)	
You are expected to do too many different tasks at the same time	423 (33.2)	353 (27.7)	500 (39.2)	
Your job is very hectic	349 (27.4)	383 (30.1)	540 (42.5)	
Your job requires that you do more with less	126 (9.9)	217 (17.0)	931 (73.1)	
Your workload is heavy	351 (27.5)	348 (27.2)	579 (45.3)	

N=1311 Source: Denton, Zeytinoglu, Davies & Lian, 2002

Table 59: Job Requires Physical Effort

Please tell us to what extent you agree/disagree with the following statements	Strongly disagree/ disagree N (%)	Neither agree nor disagree N (%)	Strongly agree/agree N (%)	Scale Properties
Your job requires physical effort	197 (15.3)	118 (9.2)	969 (75.4)	Mean: 3.7 SD: .99 Range: 1-5

N=1311

Table 60: Physical Office Environment

Please tell us to what extent you agree/disagree with the following statements	Strongly disagree/ disagree N (%)	Neither agree nor disagree N (%)	Strongly agree/agree N (%)	Scale Properties
Your work space is private	256 (57.9)	72 (16.3)	114 (25.8)	Mean: 8.4 SD: 1.66 Range: 3-15 Alpha: .69
Your office environment is quiet	239 (54.2)	81 (18.4)	121 (27.4)	
Your office furniture is not suitable for the work that you have to do *	234 (53.2)	101 (23.0)	105 (23.9)	

N=1311 * Items were reversed. Source: Zeytinoglu, Denton, Webb & Lian 2000.

Table 61: Work Extended Day

Please tell us to what extent you agree/disagree with the following statements	**None/a little of the time N (%)**	**Some of the time N (%)**	**All/most of the time N (%)**
In general do you work an extended day (compressed work week)	1014 (84.8)	124 (10.4)	58 (4.9)

N=1311 Source: Zeytinoglu, Denton, Webb & Lian 2000

Table 62: Hazards in Clients' Homes

Please tell us to what extent you agree/disagree with the following statements	**Strongly disagree/ disagree N (%)**	**Neither agree nor disagree N (%)**	**Strongly agree/agree N (%)**	**Scale Properties**
You are exposed to infectious diseases such as AIDS and Hepatitis	341 (32.5)	205 (19.6)	502 (47.9)	Mean: 26.7 SD: 5.47 Range: 8-40 Alpha: .83
You are exposed to poor physical conditions in clients' homes (cleanliness, upkeep, cockroaches)	174 (16.7)	118 (11.3)	749 (71.9)	
Clients homes are often excessively hot	203 (19.4)	217 (20.7)	628 (59.9)	
You are exposed to hazards in clients' homes and neighbourhoods (ice, dim lighting, dogs, scatter mats etc.)	259 (24.8)	113 (10.9)	672 (64.4)	
You are exposed to second hand smoke in clients' homes	146 (14.0)	91 (8.7)	809 (77.4)	
You are exposed to antibiotic resistant organisms (such as MRSA)	263 (25.6)	150 (14.6)	613 (59.8)	
You work in unsafe neighbourhoods or homes	520 (49.7)	188 (18.0)	339 (32.4)	
You are at risk of needlestick injuries in your job	564 (54.5)	174 (16.8)	297 (28.7)	

N=1082. Only workers who work in clients' homes asked to respond. Source: Denton, Zeytinoglu & Davies, 2002

Table 63: Job is Repetitious

Please tell us to what extent you agree/disagree with the following statements	**Strongly disagree/ disagree N (%)**	**Neither agree nor disagree N (%)**	**Strongly agree/agree N (%)**	**Scale Properties**
Your job requires that you do the same tasks over and over every day	341 (26.6)	256 (20.0)	685 (53.4)	Range: 1-5 Mean: 3.35 SD: 1.1

N=1311 Source: Denton, Zeytinoglu & Davies, 2002

Table 64: Victim of Crime on the Job

Please tell us to what extent you agree/disagree with the following statements	Strongly disagree/ disagree N (%)	Neither agree nor disagree N (%)	Strongly agree/agree N (%)	Scale Properties
You have been a victim of crime while on the job	1104 (86.1)	96 (7.5)	82 (6.4)	Range: 1-5 Mean: 1.77 SD: .89

N=1311 Denton, Zeytinoglu & Davies, 2002

Table 65: No Time to Travel Between Clients' Homes

Please tell us to what extent you agree/disagree with the following statements	Strongly disagree/ disagree N (%)	Neither agree nor disagree N (%)	Strongly agree/ Agree N (%)	Scale Properties
You do not have enough time to travel safely between clients' homes	448 (43.1)	230 (22.1)	362 (34.8)	Range: 1-5 Mean: 4.05 SD: .83

N=1081 Only workers who work in clients' homes asked to respond. Source: Denton, Zeytinoglu & Davies, 2002

Table 66: Organizational Support

Do you agree/disagree with each of the following statements?	Strongly disagree/ disagree N (%)	Neither agree/ disagree N (%)	Strongly agree/agree N (%)	Scale Properties
Your organization supports you in times of personal crisis, illness or needing time off to help care for other family members	154 (12.1)	246 (19.3)	877 (68.7)	Mean: 32.8 SD: 7.05 Range: 9-45 Alpha: .93
It is difficult to voice your ideas or opinions in this organization *	718 (56.3)	296 (23.2)	261 (20.5)	
Your ideas and opinions are not heard in this organization *	682 (53.6)	329 (25.9)	261 (20.5)	
Your supervisor is interested in you and your well-being	194 (15.2)	267 (21.0)	813 (63.8)	
Your supervisor appreciates your work	141 (11.1)	208 (16.4)	923 (72.5)	
Your supervisor supports you in difficult work situations	154 (12.1)	219 (17.2)	899 (70.7)	
You have sufficient personal contact with your supervisor	228 (18.0)	218 (17.2)	823 (64.8)	
You have the opportunity to talk openly with your supervisor about work-related problems	140 (11.0)	165 (12.9)	970 (76.1)	
Your supervisor is helpful in getting the job done	178 (14.1)	250 (19.8)	837 (66.1)	

N=1311 * Items were reversed Source: Zeytinoglu, Denton, Webb & Lian 2000

Table 67: Peer Support

Do you agree/disagree with each of the following statements?	Strongly disagree/ disagree N (%)	Neither agree/ disagree N (%)	Strongly agree/agree N (%)	Scale Properties
The people you work with are helpful in getting the job done	71 (5.6)	306 (24.0)	896 (70.4)	Mean: 14.4 SD: 2.99 Range: 4-20 Alpha: .83
There is opportunity to share experiences and feelings with other co-workers	233 (18.2)	262 (20.5)	782 (61.3)	
The people you work with take a personal interest in you	217 (17.1)	407 (32.1)	643 (50.7)	
Your co-workers are supportive in times of personal crises, illness or needing time off to help care for other family members	109 (8.6)	374 (29.6)	780 (61.1)	

N=1311 Source: Zeytinoglu, Denton, Webb & Lian 2000

Table 68: Control Over Work

Please tell us to what extent you agree/disagree with the following statements	Strongly disagree/ disagree N (%)	Neither agree nor disagree N (%)	Strongly agree/agree N (%)	Scale Properties
You are able to work on your own.	31 (2.4)	43 (3.3)	1213 (94.2)	Mean: 14.3 SD: 2.33 Range: 4-20 Alpha: .52
You have flexibility in scheduling your job activities.	205 (16.0)	177 (13.8)	896 (70.1)	
You have freedom to decide how you do your job.	271 (21.2)	289 (22.6)	717 (56.1)	
You have a lot to say about what happens on the job.	432 (33.9)	424 (33.3)	419 (32.9)	

N=1311 Source: Zeytinoglu, Denton, Webb & Lian 2000

Table 69: Emotional Labour

Do you agree/disagree with each of the following statements?	Strongly disagree/ disagree N (%)	Neither agree/ disagree N (%)	Strongly agree/agree N (%)	Scale Properties
You enjoy helping clients	4 (.3)	16 (1.3)	1225 (98.4)	Mean: 30.3 SD: 2.94 Range: 7-35 Alpha: .78
You enjoy meeting people as part of your job	5 (.4)	26 (2.1)	1200 (97.5)	
You worry about clients who are lonely	39 (3.2)	99 (8.2)	1072 (88.6)	
You feel needed by clients	31 (2.6)	111 (9.3)	1046 (88.1)	
You have an impact on clients' lives	37 (3.1)	114 (9.6)	1040 (87.3)	
You like the appreciation you receive from clients	16 (1.3)	79 (6.6)	1106 (92.1)	
You have an opportunity to care for/about clients	21 (1.8)	76 (6.5)	1076 (91.7)	

N=1311 Source: Denton, Zeytinoglu & Davies, 2002

Table 70: No Time for Client Emotional Support

Please tell us to what extent you agree/disagree with the following statements	Strongly disagree/ disagree N (%)	Neither agree nor disagree N (%)	Strongly agree/agree N (%)	Scale Properties
You do not have enough time to provide emotional support to clients.	264 (22.9)	204 (17.7)	686 (59.5)	Mean: 7.0 SD: 1.86 Range:2-10 Alpha: .90
You do not have enough time to provide emotional support to clients' families.	232 (20.9)	213 (19.2)	664 (59.4)	

N=1311 Source: Denton, Zeytinoglu, Davies 2002

Table 71: Client one-on-one

Please tell us to what extent you agree/disagree with the following statements	Strongly disagree/ disagree N (%)	Neither agree nor disagree N (%)	Strongly agree/agree N (%)	Scale Properties
You enjoy working one-on-one with clients	4 (.4)	36 (3.4)	1013 (96.2)	Mean: 8.5 SD: .88 Range: 2-10 Alpha: .79
You gain knowledge and learn from clients themselves	6 (.6)	44 (4.2)	1002 (95.3)	

N=1311 Source: Denton, Zeytinoglu & Davies, 2002

Table 72: Difficult Clients

Please tell us to what extent you agree/disagree with the following statements	Strongly disagree/ disagree N (%)	Neither agree nor disagree N (%)	Strongly agree/agree N (%)	Scale Properties
You deal with difficult clients	111 (9.2)	149 (12.4)	941 (78.3)	Mean: 7.6 SD: 1.6 Range: 2-10 Alpha: .70
You deal with difficult family members	209 (17.6)	173 (14.6)	805 (67.8)	

N=1311 Source: Denton, Zeytinoglu & Davies, 2002

Table 73: Receive Adequate Information on Difficult Clients

Please tell us to what extent you agree/disagree with the following statements	Strongly disagree/ disagree N (%)	Neither agree nor disagree N (%)	Strongly agree/agree N (%)	Scale Properties
You receive adequate information on difficult clients	288 (25.1)	233 (20.3)	626 (54.6)	Mean: 2.2 Range: 1-5 SD: .85

N=1175

Table 74: Exposure to Ethnic Comments

	Yes N (%)	No N (%)
Have you been exposed to inappropriate racial/ethnic comments or behaviour by clients receiving care or clients family members?	313 (25.7)	904 (74.3)

N=1311

Table 75: Exposure to Sexual Comments

	Yes N (%)	No N (%)
Have you been exposed to inappropriate sexual comments or behaviour by clients receiving care or clients family members?	358 (29.5)	854 (70.5)

N=1311

Table 76: Clients Take Advantage

Do you agree/disagree with each of the following statements?	Strongly disagree/ disagree N (%)	Neither agree/ disagree N (%)	Strongly agree/agree N (%)	Scale Properties
Some clients take advantage of you	355 (30.7)	245 (21.2)	556 (48.1)	Mean: 21.4 SD: 4.1 Range: 7-35 Alpha: .66
You get “too close” to clients.	564 (50.0)	318 (28.2)	245 (21.7)	
Some clients intrude on your private life	706 (61.7)	214 (18.7)	224 (19.6)	
Your clients view you as a “cleaning person” or “molly maid”	328 (32.3)	179 (17.6)	510 (50.1)	
You work with some clients who are receiving unnecessary services	430 (41.1)	182 (17.4)	434 (41.5)	
There is a lack of proper supplies to work with (cleaning products, aids) in clients’ homes	302 (29.3)	282 (27.4)	445 (43.3)	
You are not able to do enough to improve the client’s physical environment	234 (21.0)	280 (25.1)	601 (53.9)	

N=1311 Source: Denton, Zeytinoglu & Davies, 2002

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SEDAP RESEARCH PAPERS

Number	Title	Author(s)
No. 1:	Population Aging and Its Economic Costs: A Survey of the Issues and Evidence	F.T. Denton B.G. Spencer
No. 2:	How Much Help Is Exchanged in Families? Towards an Understanding of Discrepant Research Findings	C.J. Rosenthal L.O. Stone
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