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Migration among temporary foreign workers: Examining health and access to health care among Filipina live-in caregivers

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ABSTRACT

In 2015, approximately 14,000 migrants were accepted into Canada as live-in caregivers. While extensive research has documented the working conditions of migrant live-in caregivers, few studies examine the health experiences of this population related to their employment as caregivers. This research examines the relationship between employment under the Federal Government's (Live-in) Caregiver Program and health and access to healthcare services among 21 Filipina caregivers working in the Greater Toronto Area, Ontario. Results of in-depth interviews reveal that long work hours are perceived to negatively affect physical health while separation from family negatively impacts mental health. Among the women interviewed, work responsibilities and living-in the place of employment are perceived to negatively impact both physical and mental health. The research also demonstrates that working as a live-in caregiver both facilitates and creates barriers to accessing health services. Future research is needed to better understand the health of more socially isolated caregivers and caregivers living-out(side) their place of employment.

1. Introduction

The number of global migrants reached an all-time high of 258 million in 2017 (UN, 2017). Many developed countries rely on international migrants to strengthen national economies, contribute to population growth, and to fill labour shortages (Canada, 2017a; U.S., 2016). In Canada, an aging population and below replacement fertility rates means that immigration represents an important source of population growth. By 2031, immigration is projected to account for over 80 percent of Canada's population growth (Canada, 2016a).

In contrast to permanent migration, migration can be temporary. Permanent international migrants are defined as individuals moving to a new country with similar rights to native-born citizens (Waters, 2009). Temporary international migrants, on the other hand, migrate for a limited amount of time for specific purposes. In 2011, 1.9 million individuals migrated as temporary labour migrants to OECD nations (OECD, 2013). When migrating across borders, migrants must meet various requirements depending on the type of migration. For example, in Canada, individuals can permanently migrate under four categories: economic class, family class, refugees and other (Canada, 2015). Individuals can also migrate temporarily under the Temporary Foreign Worker Program (TFWP) (Canada, 2017a).

A large body of research has focused on the health of mainly permanent immigrants across the globe (for example, Biddle et al., 2007; Omariba et al., 2014; Vandenheede et al., 2015). While important for documenting changes and comparisons in health between permanent migrants and native-born populations, less is known about health and healthcare experiences among temporary migrants (but see, Arcury and Quandt, 2007; Hennebry et al., 2016; Mayell and McLaughlin, 2016). The objective of this paper is to contribute to the growing literature on the health of temporary foreign workers by examining perceived changes in health and barriers to accessing healthcare services among Filipina women working as temporary live-in caregivers in the Greater Toronto Area (GTA), Ontario, Canada.

1.1. Employment and health

A large body of literature has documented the relationship between employment and health establishing that employed individuals are healthier than individuals who are not employed (for example, Asanin-Dean and Wilson, 2009; Park et al., 2016; Paul and Moser, 2009). While the literature demonstrates a correlation between positive health outcomes and employment, there are two competing schools of thought explaining this relationship.

On the one hand, researchers argue that it is the act of being employed that fosters good health, thereby resulting in employed individuals being healthier than unemployed individuals (Ross and Mirowsky, 1995). For example, research has shown that employed

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individuals have better physical and mental health than those who are unemployed (McKee-Ryan et al., 2005; Park et al., 2016); and that unemployment is linked to poor health outcomes (Paul and Moser, 2009; Yur'yev et al., 2012).

In contrast, others consider the role of selection in explaining the relationship between employment and positive health outcomes (Asanin Dean and Wilson, 2009). As Asanin Dean and Wilson (2009, p.188) note: "The selection of those who are healthy into positions of employment has been best observed through the 'healthy worker effect', which suggests that individuals with better health tend to seek employment more so than those who are unhealthy." A pivotal study by McMichael (1976) found that males in the U.S. with higher rates of illness and disability were less likely to actively seek work and therefore less likely to secure employment than healthier individuals. Additional studies have found evidence to support the existence of a healthy worker effect (Olesen et al., 2013; Schuring et al., 2007; Virtanen et al., 2013).

With such a large body of literature showing a positive association between employment and health, it is undeniable that employment plays a role in shaping health. Indeed, employment and its direct and indirect benefits (e.g., access to healthcare, income, health insurance, social support) are recognized as social determinants of health (Canada, 2016b; WHO, 2018). That said, research examining the link between employment and health tends to focus on general populations with little to no distinction between different migrant groups.

The literature shows a large number of studies examining health issues among temporary foreign workers, but the literature is mainly focused on migrant agricultural workers in the U.S. (see Arcury and Quandt, 2007). In contrast to the large body of literature conducted in the U.S., a relatively smaller number of studies in Canada examine the health of temporary foreign workers but also with a focus on seasonal agricultural workers (see Hennebry et al., 2016; McLaughlin et al., 2014; Mayell and McLaughlin, 2016; Preibisch and Hennebry, 2011). For example, Hennebry (2010) found that among migrant agricultural workers in Southern Ontario, poor living and working conditions put workers' health at risk. Recent work has also demonstrated barriers to accessing healthcare services among temporary seasonal agricultural workers including discrimination, difficulty getting time off work, lack of knowledge about where to receive care, not having insurance, language, and transportation (Hanley et al., 2014; Narushima et al., 2016; Preibisch and Otero, 2014).

While research has documented a relationship between employment and health/access to healthcare among temporary agricultural workers, the findings from this research may not translate to other types of temporary workers such as foreign live-in caregivers. Only a small body of literature has examined the health of Filipina domestic workers (see Hanley et al., 2010; Spitzer, 2008; Spitzer and Torres, 2008; Spizter et al., 2002; van der Ham et al., 2015; Vahabi and Wong, 2017). Much of the research has examined the health of Filipina domestic workers who are employed in the Middle East and Southeast Asia (Ayalon, 2012; Ayalon and Shiovitz-Ezra, 2010; Nakonz and Shik, 2009; Malhora et al., 2013).

A limited but important body of research has examined the health of Filipina domestic workers in Canada. For example, Spitzer et al. (2002, p.30) argue that live-in caregivers experience stress because of "unfamiliarity with the society and employer, concern about family at home and the inability to fulfill their requests for money, constant reprimands from employers, disobedience from children, juggling the demands of work, worrying about applying for permanent residency status, lack of food and privacy, and profound loneliness" (see also Cohen, 2000; Pratt, 2009).

In summary, while a somewhat large body of literature has examined the health impacts of employment among seasonal agricultural workers a relatively smaller group of studies have begun to focus on the link between employment and health among foreign live-in caregivers. In order to understand the nuances of this link it is necessary to understand the nature of Canada's Live-in Caregiver Program (1992–2014).

1.2. Canada's live-in caregiver program

Enacted in 1992, the Live-in Caregiver Program (LCP) was created to fulfill a deficit of live-in assistance due to the lack of willingness amongst Canadians to fill employment opportunities involving live-in domestic labour (Atanackovic and Bourgeault, 2014). The LCP allows individuals to migrate to Canada as private live-in caregivers for children, the elderly, and the disabled. The program is unique in that migrant caregivers can transition from being a temporary worker to a permanent resident after completing 24 months of employment as a live-in caregiver. In November 2014, a significant change was made to the LCP resulting in the creation of the Caregiver Program (CP). The main change was the removal of the live-in requirement as much research has demonstrated that it results in exploitation (e.g., unpaid overtime and excessive work hours) and family separation (Canada, 2014a; Khan, 2009; Pratt, 2009). The CP includes two new pathways to permanent residency: i) Caring for Children; and ii) Caring for People with High Medical Needs. Changes also include an increase in educational requirements and the completion of a language test (Canada, 2014b). While the LCP/CP policies outline a clear path to permanent residency, transitioning from temporary live-in caregiver to permanent resident is not simple. Instances of long wait periods for permanent residency and denial of permanent residency due to health issues are not uncommon (Keung, 2009, 2015). In some instances, caregivers are denied permanent residency to Canada as a result of emerging health issues. One notable example is the case of Juana Tejada. Tejada came to Canada in 2003 to work as a live-in caregiver. While she passed the medical screening required for admission into the country, when Tejada applied for permanent residency in 2006 she was diagnosed with colon cancer and her application was denied as she was deemed a health burden (Keung, 2008, 2009). Interestingly, only 56 percent of migrant live-in caregivers who migrated to Canada in 2005–2009 became permanent residents (Canada, 2017b). More recently, in 2015, only 331 individuals enrolled in the LCP were granted permanent residency (Canada, 2016c).

Women make up the majority of participants in the program, accounting for over 90 percent of all caregivers (Kelly et al., 2011). Approximately 90 percent of caregivers migrate from the Philippines (Kelly et al., 2011).

Over the past 20 years, an emerging body of literature has shed light on the employment related experiences of live-in caregivers. The literature has mostly focused on negative experiences resulting from employment as a migrant live-in caregiver. For example, a recent study by Tungohan et al. (2015) conducted in Montreal, Toronto, Ottawa, Calgary, Edmonton, and Vancouver reveals that employer-specific work permits, the live-in requirement, and a lack of enforcement of employment contracts leads to mistreatment of caregivers (see also Atanackovic and Bourgeault, 2014; Stasiulis and Bakan, 2005).

Research also demonstrates the exploitative gendered and racialized nature of the live-in caregiver program (see Stasiulis and Bakan, 2005). Khan (2009) reveals how the Philippines' labour-export policies, poverty and unemployment, in combination with stereotypes of Filipina women as being nurturing and complacent make recruiting live-in caregivers to Canada from the Philippines preferred over other countries. Similar stereotypes of Filipina caregivers as "uncivilised", loving and patient, and lesser than European caregivers among Canadians have been noted to lead to unacceptable wage and work conditions (Pratt, 1997). While understanding the complex and gendered nature of this type of temporary employment is critical for better understanding potential short and long-term negative impacts of the LCP, issues related to health, well-being, and access to health services have been investigated to a lesser extent.

As developed nations increasingly rely on migrants to fill labour