# COMMUNITY HEALTH WORKERS AND PERSONAL SUPPORT WORKERS

Sara Torres, Simone Parniak and Christine Kelly

# Community Health Workers and Personal Support Workers

## INTRODUCTION

Policymakers are increasingly showing interest in the 'unregulated' health workforce, which has been largely under-recognized in Canada. Among this workforce are two key groups, community health workers (CHWs) and personal support workers (PSWs), which can be sorted into three categories: CHWs who participate in health promotion (leading to community mobilization and empowerment) and education activities (focused on the prevention and management of infectious and chronic diseases); CHWs who provide medical care or clinical support for patients (such as oral care and vaccinations), especially in rural or remote areas; and PSWs who support their clients' daily activities either at home or in long-term care facilities (Bourgeault et al., 2009).

In general, CHWs focus on increasing access to health and/or social services for marginalized groups and on building community capacity. PSWs, on the other hand, support and assist people who lack mobility or have chronic illnessess or permanent disabilities (Bourgeault et al., 2009; Brookman, 2007; Government of Ontario, 2011; Kelly & Bourgeault, 2015a; Torres, 2012). Both groups assist marginalized individuals and those receiving various levels of care ranging from preventive to chronic care services, and are able to provide culturally responsive services to the populations they serve.

The respective roles of CHWs and PSWs indicate that, while these workers are sometimes considered auxiliary, they are essential to Canada's health workforce. Often experiencing marginalization themselves, these workers are disproportionately

female, immigrant and/or lower income. Educational backgrounds vary dramatically from professional degrees (typically foreign-trained) to primary or secondary education (usually mainstream Canadians or Indigenous peoples).

This chapter identifies the various roles CHWs and PSWs play as part of Canada's health workforce.

# Community Health Workers

By Sara Torres

## DEFINITION OF THE PROFESSION

Community health workers (CHWs) are frontline health workers who are members of the communities they serve. Often an invisible and unrecognized workforce, CHWs can be the bridge between communities on the margin — such as immigrants, Indigenous peoples and persons with disabilities — and health professionals. CHWs generally have a deep understanding of the issues these communities face in accessing health and social services (Torres, Labonté, Spitzer, Andrew, & Amaratunga, 2014). In addition, CHWs often share the language, beliefs and sociocultural characteristics of their communities. For example, CHWs working with immigrant, refugee or Indigenous populations are able to offer linguistically and culturally appropriate services and support.

CHWs focus more broadly on health education and health promotion, with their activities aimed at helping individuals, groups and communities to change behaviours, improve access to health and other essential services, build community capacity, and address health inequities among marginalized populations.

Alternative job titles for CHWs include multicultural health brokers, cultural brokers, lay health workers, *promotoras de salud* (Spanish for health promoters), peer support workers, community health representatives, women's health educators and non-traditional health care workers (Torres, 2013).

## HISTORY OF THE PROFESSION

### THE EARLY HISTORY OF CHWS

CHWs have existed for several hundred years in low-income countries, with names such as the 'Feldshers' in the 1700s in Russia and 'barefoot doctors' or 'village workers' in the 1950s in China (Lehmann & Sanders, 2007). In Latin America, the work of liberation theologists such as Paulo Freire helped to popularize the term '*promotoras de salud*' (health promoters) in the 20th century. In high-income countries such as Canada, CHW models were introduced in the 1960s to address a variety of health issues among marginalized communities. Books such as *Where There is No Doctor* (Werner, 1977) and its sequel, *Helping Health Workers Learn* (Werner & Bower, 1982), popularized the CHW role worldwide.

### THE ORIGIN OF CHWS IN CANADA

CHWs have existed in Canada since 1962, when community health representatives (CHRs)—funded by Health Canada and administered by band councils—worked with Indigenous communities. In 2000, the National Indian & Inuit Community Health Representatives Organization won a court case that redefined CHRs' job classification and brought their wages in line with that of Health Canada workers doing the same or similar job (NIICHRO, 2008). After this decision, Health Canada's funding to band councils was restructured, with the new model not reflecting the reclassification or new wage rate. While band councils could hire CHRs, they often worked under a different title and therefore did not fall within the new CHR classification. As a result, wages were just $10 per hour rather than being comparable to those of Health Canada workers (Dedam-Montour, 2010).

### THE PAN-CANADIAN COMMUNITY HEALTH WORKERS NETWORK OF CANADA

CHWs have also worked in urban areas for several decades but have only recently formed the pan-Canadian Community Health Workers Network of Canada (CHWNC), which was created to tackle issues such as who does what across the country; the merits of developing a common definition for CHWs; the scope of CHWs' practice; the potential for developing core competencies for CHWs; promoting formal recognition for the CHW workforce by the Canadian Association of Public Health and other entities; and conducting further research on CHWs and the potential for their work to address health inequities among marginalized populations (CHWNC notes, 2013–2014; Torres et al., 2014).

CHWNC members are from two different CHW models: those operating within the formal health-care system (e.g., public health units, community health centres, hospitals) and those operating independently of the health-care system (e.g., in ethno-specific and multicultural community-based organizations and provincial organizations) (Torres, 2013). Network members deliver CHW programs that include prevention and management of infectious and chronic diseases (cancer screening and diabetes and HIV education); support for people with disabilities; community development promotion; and other activities that address the social determinants of health (www.chwnetwork.ca).

## COMMUNITY HEALTH WORKER EDUCATION IN CANADA

### CHW TRAINING AND EDUCATION

Because CHWs in Canada are not formally organized as a recognized public health occupation, the level of training, education and experience can vary widely from one CHW to the next. For example, while some have completed various levels of post-secondary education, others have been unable to access formal education, often due to their social and economic circumstances. In addition, many are foreign-trained professionals who have been unable to find jobs in their original fields upon arriving in Canada. A small number are graduates of Canadian universities who are committed to working as CHWs for their communities, even though wages and salaries may not be comparable to other positions in the health-care field (Torres, 2013). Regardless of their level of training and education, all CHWs must have a deep knowledge of the communities they serve and of how Canadian health and social services systems work.

Training for CHWs is typically subject-matter specific and conducted while on the job, and is generally based on the needs identified by the entities that hire them (e.g., public health units, community health centres, community-based organizations) (Torres, 2013).

### CHR TRAINING AND EDUCATION

In contrast to other CHWs, CHRs have fought for many years for recognition in Canada. As a result, there are a number of training programs provided by educational institutions to meet the health needs of Indigenous populations. Among these are programs provided by the Cree Board of Health and Social Services of James Bay; Confederation College in Thunder Bay, Ontario; and Alberta Vocational College in Lac La Biche, Alberta (Najafizada, Bourgeault, Labonté, Packer, & Torres, 2015).

## COMMUNITY HEALTH WORKER DEMOGRAPHICS

### CHWS IN THE UNITED STATES

Compared to their Canadian counterparts, CHWs in the United States have a longer history of organizing to have their profession formally recognized as a public health occupation. The development of the American CHW workforce has also been better documented; for example, in 2007, the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services conducted the CHW National Workforce Study (HRSA, 2007); its findings (along with numerous other policy advocacy efforts put forth by CHWs) have positively affected the recognition of CHWs in that country. In total, 17 states are currently in the process of establishing standards for CHWs (Findley et al., 2012). Since 2010, CHWs have had their own Standard Occupational Category — SOC #21 — 1094 Community Health Worker — recognizing these workers as a distinct occupation (Balcázar et al., 2011; Federal Register, 2009). The 2010 *Patient Protection and Affordable Care Act* also recognizes the role CHWs play in improving health outcomes and containing costs (Martinez et al., 2011).

### ETHNICITY OF CHWS

As indicated in the 2007 U.S. CHW National Workforce Study, CHWs usually mirror the demographic characteristics of the communities they serve. While there is a lack of similar aggregate data in Canada, this finding appears to correlate with what is known about CHWs in this country. For example, a case study of 54 CHWs in Edmonton (where they are referred to as 'multicultural health brokers') found that CHWs of various ethnic backgrounds typically work in their own communities (Multicultural Health Brokers Co-operative, 2004).

### GENDER OF CHWS

The U.S. survey also indicates that CHWs are mostly women between the ages of 30 and 50. The predominance of women is partly due to the focus of many programs on underserved children and their mothers (HRSA, 2007). Although Canada does not have data regarding the number and gender of CHWs, it reasonable to assume that many CHWs are women because they are often the targets of a variety of health-related programs. For example, CHWs participate extensively in Canada's Prenatal Nutrition Program (CPNP), which targets 18,000 mothers who are at risk of delivering low birth weight and/or pre-term babies (PHAC, 2010). The U.S CHW National Workforce Study found exceptions in certain programs where male CHWs predominated, such as nutrition, fatherhood, HIV case management programs and some youth programs (HRSA, 2007). This is also true in Canada, where male CHWs are working to help youth in large cities leave street gangs (L. Carrillos, personal communication, May 28, 2014).

## SCOPE OF PRACTICE FOR COMMUNITY HEALTH WORKERS

There are several roles, principles and characteristics that guide CHW practice (Lewis & Craig, 2014; Torres, 2013; Wolfe, 2010). Depending on the mandate of the agencies where CHWs work, their tasks might involve a combination of some or all of the following:

#### *1. Outreach and mobilization*

CHWs reach out to individuals and families who may be unable to access or effectively use health services due to factors such as low socioeconomic status, lack of fluency in English or French, isolation, gender marginalization and discrimination. CHWs provide health-related information to these people about disease prevention and management, encourage participation in health programs, and accompany them to medical appointments. CHWs also mobilize lobbying and advocacy efforts in their communities to address issues relating to the social determinants of health.

#### *2. Community and cultural liaising*

CHWs create and foster connections among individuals, families and communities; they also act as intermediaries between these groups and health and social services providers, working to translate issues related to cultural beliefs, needs and behaviours (Lewis & Craig, 2014). This includes helping mainstream health and social services professionals understand, for example, how immigrant and refugee populations adapt to their new communities.

#### *3. Case management, care coordination and system navigation*

CHWs help individuals and families assess, plan, facilitate and advocate for services while also assisting them to navigate and understand their options, take care of their health, manage crises and access services (Lewis & Craig, 2014).

#### *4. Program planning and advocacy*

CHWs plan, organize and develop health promotion programs and initiatives that help people exercise control over their health and its determinants, thereby improving their health (World Health Organization Commission on the Social Determinants of Health, 2005). These include activities that foster equity, holism, intersectorality and an ecological approach (Rootman et al., 2001). For example, CHWs help individuals (especially women) referred to them for perinatal or health-related services secure the support they need, helping them address financial and housing difficulties or issues such as family violence. As a result, CHWs work to find multi-faceted solutions to their client's problems by drawing on resources from government ministries and health and social service agencies, and by enlisting women to support other women and their communities (Torres, 2013; Torres et al., 2014).

### MODELS OF PRACTICE

Peer-reviewed literature on the models of practice used by CHWs is scarce. In Canada, a case study of multicultural health brokers in Edmonton revealed that their practice is driven by a theoretical understanding of what strengthens communities and families (Torres, 2013). They are influenced by cultural brokering theory/multicultural health brokering theory (Jezewski, 1995; Ortiz, 2003) and by a health promotion empowerment approach (Labonté, 1993). Other CHW programs (such as the CPNP, which is delivered by both volunteers and paid CHWs) are more strongly influenced by biomedical approaches to health education and promotion. In general, CHWs exist due to gaps in health and social services. By complementing other workers, CHWs help public systems fulfill their mandates to serve all populations.

## REGULATION OF COMMUNITY HEALTH WORKERS IN CANADA

In Canada, CHWs are not regulated and professionalization is not yet prominent on Canadian CHWs' agenda; however, it is a topic that has been addressed in some research studies (Torres, 2013; Wolfe, 2010). This may change as CHWs become more visible as health workers in Canada.

### REGULATION IN THE UNITED STATES

There have been debates related to regulation between CHWs in the U.S., especially among those who believe standardization and regulation would deter the independence and integrity of their work (CHWNC, 2014; S. Matos, personal communication, January 30, 2014; Torres, 2013). Some CHWs worry that regulation may move CHW roles toward technical tasks and practices that are traditionally performed within the scope of health services—and away from intersectoral actions, community development and social participation (Rodrigues Fausto et al., 2011).

## FUNDING OF COMMUNITY HEALTH WORKERS AND COVERAGE OF SERVICES

Salaries and benefits for CHWs vary depending on whether the hiring body is within the health-care system (e.g., public health units) or a non-governmental organization (e.g., ethno-cultural groups). CHWs within the health-care system usually receive benefits and have reasonable work hours and caseloads; this is often not the case for CHWs operating independently of the health-care system (Torres et al., 2014). The 2007 U.S CHW National Workforce Study found that 60% of new CHWs are paid USD $13 per hour, with 3.4% paid at or near the minimum wage (i.e., less than USD $7 per hour). In addition, 70% of experienced CHWs receive USD $13 per hour or more and about half of them receive more than $15 per hour (HRSA, 2007). Many CHWs forego pay and benefits, choosing to volunteer within health-care system institutions and community-based organizations.

## KEY ISSUES FOR COMMUNITY HEALTH WORKERS

### WAGES AND CREDENTIAL RECOGNITION

While CHWs are finding a niche in the economy (Calliste, 2000), there are still many CHWs who can find only part-time positions (Ghorayshi, 2002). Many CHW positions are defined as low-skilled (Armstrong & Armstrong, 2010; Ghorayshi, 2002). Workers are also exploited, frequently not being paid enough to make living wages (Wolfe, 2010). Many female immigrant CHWs have more education than their Canadian-born counterparts (Ghorayshi, 2002), but because their professional credentials are not recognized, they cannot work in their chosen field and opt to become CHWs.

### ACCESS TO SERVICES

CHWs connect marginalized people to the services and support they need, a service that health and social services agencies staff are often unable to offer. Similar to those they serve, CHWs face many barriers in facilitating access to health and social services, both personally and professionally. These barriers include language, racism, gender and low socioeconomic status (Torres, Balcázar, Rosenthal, Labonté, Fox & Chiu, 2017).

### BREAKING NEW GROUND

CHWs are forging a new type of relationship between clients and workers—and between communities and their health and social services agencies—that both differs from and complements the practices of other health-care professionals such as nurses, doctors and social workers.

# Personal Support Workers

By Simone Parniak and Christine Kelly

Personal support workers (PSWs) are the 'engine' of Continuing Care, whether that care takes place in private homes, residential centres or group homes. PSWs perform the majority of hands-on assistance for older people, people with disabilities and those who need assistance in daily life. Similar to CHWs, PSWs are often marginalized themselves, with disproportionate representation from immigrants, women and those with lower income and education levels. Among others who provide ancillary services, PSWs are considered to be "critical to care" (Armstrong, Armstrong & Scott-Dixon, 2008). However, these vital workers are often devalued, poorly compensated and invisible in policy discussions.

## WHAT IS A PERSONAL SUPPORT WORKER?

### SUPPORT WORKER TERMINOLOGY

PSWs assist older adults and people with disabilities living in long-term care homes, retirement homes and community settings with a wide variety of tasks (Kelly & Bourgeault, 2015a). The terms used to describe this work vary from province to province; for example, continuing care assistants, health care aides, home health aide, home support aide, health-care attendant and visiting homemaker are often used in different contexts to refer to similar work (Lum, 2013). Workers for adults with physical disabilities are often distinguished from the broader category and are called attendants or personal attendants. These workers may follow a unique 'Independent Living' approach to providing assistance where the client specifically directs the worker in how to provide assistance (HPRAC, 2006; OCSA, 2009a, 2009b). Workers who provide assistance to those with developmental disabilities are often referred to as developmental support workers (DSWs).

### WHAT PSWS DO

Despite varied terminology, there is an identifiable group of paraprofessionals working alongside or in lieu of professional health-care workers to perform the majority of hands-on assistance in various continuing care settings: helping with personal hygiene; caring for feet; positioning clients to ensure their comfort; and assisting with daily activities like dressing, bathing, toileting and eating. In home settings, PSWs may also undertake other domestic activities such as caring for children, shopping and house cleaning (Lilly, 2008; OCSA, 2009b). In short, "PSWs do the things that the person would do for herself, if she were physically and/or cognitively able" (PSNO, 2014).

## HISTORY OF THE PROFESSION

### THE ORIGIN OF PSWS

The PSW category emerged with the evolution of the nursing profession. Through formal education and accreditation, nursing knowledge became increasingly specialized through formal education and accreditation (Mansell & Dodd, 2005). In the 1990s, as political and public pressure to reduce health-care costs escalated, it became too costly to employ nurses to perform 'non-specialized' tasks such as those handled by PSWs. Registered nurses were shifted to more managerial and supervisorial roles, while continuing care was turned over to licensed or registered practical nurses (LPNs or RPNs) and PSWs. Although nurses in Canada are unionized, they still continue to fight for adequate compensation and equitable working conditions (Richardson, 2005).

### THE PARADOX OF THE PSW

Along with the pressure to cut costs, the 1990s also brought about efforts to limit hospital stays (Sutherland & Crump, 2011). As a result, patients were sent home much sooner after illness or surgery, or were transitioned

to continuing care while in medical states that typically would have been treated in hospital. Again, PSWs emerged to fill this gap. This creates a paradox as PSWs represent both non-specialized, 'affordable' care while also possessing the semi-specialized knowledge and skills essential to transitioning and supporting individuals within Canada's health-care system (Denton et al, 2015; Saari et al, 2018).

## PERSONAL SUPPORT WORKER EDUCATION IN CANADA

### TRAINING STANDARDS

The education and training of PSWs has been a topic of contention throughout the 1990s and 2000s, and there is a move towards more standardization, depending on the province. In Ontario, a number of PSW training programs are offered in person and online through private and public colleges and school boards, and some employers include education requirements in their job postings. The Ontario Community Support Association developed provincial standards in the early 1990s but experienced difficulties when trying to implement them (OCSA, 2009a). Similarly, the Association of Canadian Community Colleges (ACCC) developed and promoted the Canadian Educational Standards for PSWs; however, educational programs are not obligated to conform to these standards (ACCC & CACCE, 2012). The Long-Term Care Homes Act (2010) required all PSWs hired after July 1, 2011 have completed a PSW training program to work in publicly-funded long-term care homes. As there are no established educational prerequisites and there is a great deal of variability in the quality of PSW training programs, several academic and community organizations have raised concerns about PSW training standards (HPRAC, 2006; Keefe, Martin-Matthews, & Legare, 2011; Lilly, 2008). In July 2014, the Ontario Ministry of Training, Colleges and Universities (MTCU) released a common education standard that applies to all PSW training programs (MTCU, 2014). This standard includes 14 vocational learning outcomes, essential employability skills and a general education requirement.

In Nova Scotia, there are educational requirements that must be met for PSWs (called Continuing Care Assistants, CCAs) to work in nursing homes and agencies that provide home care (Laporte & Rudoler, 2013). They must be a graduate of a recognized CCA program delivered by a licensed education provider and successfully pass the Nova Scotia CCA Certification Exam (http://www.novascotiacca.ca/).

In Alberta, health care aides require certification gained through completion of a college degree[1]. In 2005, Alberta Health developed the Health Care Aide (HCA) Government of Alberta Provincial Curriculum. In 2010, the curriculum was updated and provided to licensed public and private post-secondary institutions, and to employer organizations for use in health care aide education programs in the province[2].

### PROGRAM ADMISSION

Eligibility requirements for PSW training programs vary depending on the program. In Ontario and Nova Scotia, for example, community colleges generally require a secondary school diploma or a General Educational Development (GED) certificate prior to application, although this is not always necessary for admission to a private college or adult education program. PSW certificates from private colleges are especially scrutinized as these schools often focus on an individual's ability to pay the program fee rather than on providing high-quality training, and may mislead students through false advertisements (Servage, 2008). Eligibility for employer-led onsite training depends on the organization but typically presumes employment as a prerequisite. It is important to note that employment agencies encourage many immigrants to pursue PSW training due to presumed job availability. As in other care-related positions, like CHWS, PSWs are part of a trend where internationally educated health professionals who's credentials are not recognised are integrated into unregulated roles. (Atanackovic & Bourgeault 2014).

1 www.health.alberta.ca/professionals/health-care-aide-programs.html
2 www.health.alberta.ca/professionals/health-care-aide-curriculum.html

**Figure 1:** Sectors of work for Ontario PSWs according to the Ministry of Health and Long-Term Care, 2011


## PERSONAL SUPPORT WORKER DEMOGRAPHICS

Because the profession is unregulated and many PSWs work in part-time, casual or private arrangements to accommodate the needs of their patients, it is difficult to account for PSWs in Canada. In Nova Scotia, registration with the Continuing Care Assistant (CCA) Registry is voluntary; as of March 31, 2018, the CCA Registry had 1047 active members. Numbers vary across different reports, with an estimated 90,000 PSWs in Ontario alone. The estimated distribution of Ontario PSWs in various work sectors is displayed in Figure 1 (Ministry of Health and Long-Term Care, 2011). These data came from the Ontario PSW Registry that was shut down in 2016 over concerns regarding data quality, so caution is needed in interpreting these data.

### AGE AND EDUCATION LEVEL OF PSWS IN ONTARIO

A study by Lum (2013) focused on the self-reported data presented by 32,302 individuals in the afore-mentioned Ontario PSW Registry who work primarily in public home care agencies. More than half of the PSWs in the Registry are between the ages of 40 and 59, and the majority (92%) are female. While most PSWs indicated that they hold a PSW certificate, some provided other credentials such as home care aide certificate or personal attendant certificates. More than 30% of PSWs have more than 10 years of experience in the profession.

### WHERE PSWS WORK

Nearly half of PSWs in the Registry worked in home and community care; the second-most popular workplace was long-term care homes. However, these numbers are likely skewed as joining the Registry was only mandatory for those working in public-funded home care settings. This explains the discrepancy between the Registry data and the data collected by the Ministry of Health and Long-Term Care detailed in Figure 1. Other employment settings included retire-ment homes, hospitals and attendant services. Most PSWs reported working between 20 and 40 hours per week, with 27% working more than 40 hours per week.

## SCOPE OF PRACTICE FOR PERSONAL SUPPORT WORKERS

### WHO PSWS SUPPORT

PSWs typically support older adults living at home or in residential care homes who require assistance due to their changing needs and abilities (which are then compounded by current social structures that many argue inadequately accommodate aging populations). PSWs may also help individuals of any age while they are recovering from surgeries, acute illness or injuries. Other people with physical disabilities may require ongoing support; these individuals may endorse an 'independent living' model of support and prefer to take a medicalized approach to their needs, indicated by use of alternative terminology such as 'attendant' (Kelly, 2016).

### COMMON VALUES GUIDING THE WORK OF PSWS

According to the Ontario Community Support Association (2009b), there are six common values that should guide the approach of PSWs and attendants:

1. Support and promote client rights
2. Individualize services to suit preferences and directions of the consumer
3. Respect the dignity of the client
4. Provide culturally sensitive services
5. Respect the roles of family, friends and other caregivers
6. Work as a member of a team, including client, family and other service providers

These values reflect the diversity of clients as well as the settings in which PSWs work.

## REGULATION OF PERSONAL SUPPORT WORKERS IN CANADA

### CLASSIFICATION OF PSWS

In Canada, PSWs are not self regulated health workers in the way that many health professions are regulated. In Ontario, for example, PSWs are neither classified as health professionals nor permitted to independently carry out acts that are classified as "controlled" under the Regulated Health Professions Act (1991) without the supervision of a regulated health professional. There are exceptions for attendants performing "activities of daily living" (e.g., routine catheterization)—and these exceptions are part of what distinguishes attendants from PSWs (HPRAC, 2006). The work of PSWs is, however, highly regulated through the regulation of the settings in which they work.

### THE SELF-REGULATION QUESTION

There is some confusion among PSWs about regulation: some educational programs boast "certification" upon completion, but this should not be misinterpreted as a form of occupational regulation which requires significant infrastructure. Certain PSW work settings (long-term care homes, for example) are highly regulated in other ways, for example, through legislation, ministry directives and reporting requirements.

The question of regulation is a central issue for these workers—and has been addressed in some form in different provincial contexts.

In Ontario, the question of regulation has come up repeatedly. In 2006, the Minister of Health and Long-Term Care commissioned a report by the Health Professions Regulatory Advisory Committee (HPRAC, 2006), which concluded that PSWs should not be regulated at that point in time. This report also explored and then dismissed the idea of creating a registry as an alternative to regulation. In contrast to the report's recommendations, in 2011 the Ontario government announced the creation of a PSW registry that all PSWs working in government-funded home care programs must join. The purpose of the registry was somewhat ambiguous, as it did not clearly follow one of the three potential functions identified by the HPRAC report (certification, incident reporting or record of dismissals) (HPRAC, 2006). Some groups resisted formation of the registry, including the Canadian Union of Public Employees (CUPE, 2012). The registry was cancelled in 2016, and a re-design was announced in 2018 – another indication of the disagreement around this topic. The common education standard for PSWs suggests alternative mechanisms to standardize and monitor this field without necessarily transitioning to a regulated health profession (Kelly & Bourgeault, 2015b).

In British Columbia, the provincial government implemented a registry for PSWs to be used primarily for filing abuse allegations and to avoid hiring abusive workers (Laporte & Rudoler, 2013). A registry also exists in Nova Scotia with the aim of connecting registered workers with employers (Laporte & Rudoler, 2013). In Alberta, the Health Care Aide Registry was launched in May, 2017 (http://www.albertahcadirectory.com/). These efforts do not necessarily indicate PSWs will become a self-regulated health profession.

## FUNDING OF PERSONAL SUPPORT WORKERS AND COVERAGE OF SERVICES

### SALARIES

Salaries for PSWs depend on a number of factors, particularly the employer, worksite and province where the PSW works. According to the Personal Support

Network of Ontario, salaries range from CAD $14 to $25 per hour (PSNO, n.d.). The current minimum wage for publicly funded PSWs in Ontario is $16.50 per hour as of April 2016. Those hired based on the regulations of the Ontario Long-Term Care Homes Act are paid $18 per hour as PSWs, but those hired to fill part-time positions are not provided benefits (PSNO, n.d.). This often occurs in government-funded homes where the government contributes $1,500 a month per client, with the client contributing the same amount to stay in a room of the facility (PSNO, n.d.). Often PSWs work casual or part-time positions, which can affect their annual income.

In private facilities, clients can pay anywhere from $3,000 to $5,000 per month for a room and caregiver services (PSNO, n.d.). Many private homes hire untrained PSWs for an hourly wage of only $13, but will offer full-time employment and opportunities for those hired so they can obtain the required PSW training while working in Ontario.

### SELF-EMPLOYMENT

Some PSWs start their own businesses providing home care, earning an average salary of $20 per hour (PSNO, n.d.). Self-employed PSWs can experience the benefit of working for multiple clients without the help of an agency (which often deducts fees from the PSW's wages), and can secure benefits such as professional liability insurance through the National Association of Career Colleges (NACC).

## KEY ISSUES FOR PERSONAL SUPPORT WORKERS

### TURNOVER

Despite increasing demands for PSWs, the profession has a high turnover rate. A study exploring the turnover rate of PSWs employed by three different non-profit agencies found that between 1996 and 2001, 50% of the PSWs left their jobs (Denton, 2006). Reasons for leaving included finding a job with better pay or benefits, or not being able to handle the large workload that came with the job. Another study on this topic found that large long-term care homes were associated with higher rates of PSW turnover (Wodchis et al., 2007). Onsite PSW training was associated with higher rates of PSW retention, which is an interesting consideration for employers experiencing turnover issues (Wodchis et al., 2007).

The reasons cited for this high turnover vary. It is worth noting, though, that Canadian PSWs are exposed to high rates of workplace violence, particularly in long-term care facilities (Armstrong et al., 2011; Daly et al., 2011). Workers in long-term care in Canada also report higher levels of physical and mental exhaustion than their counterparts in other countries, as well as a lack of time to talk about workplace difficulties.

### REGULATION AND STANDARDIZATION

Education and regulation remain contentious issues for PSWs in Canada. While there is a push to standardize PSW education, work contexts vary greatly, making this a difficult goal to achieve. In addition, the needs and expectations of clients are also highly variable, complicating goals for standardization. Regardless of these issues, the demand for PSWs will continue to grow as Canada's population ages, underlining the importance of this under-recognized field.

## CONCLUSION

This chapter adds to the literature describing the context of the work CHWs and PSWs do in Canada and their roles within the health workforce. CHWs and PSWs complement and supplement the work of other health-care professionals, yet they occupy the lower echelons of the hierarchical health-care system CHWs have the potential to promote individual and community capacity and empowerment, while the role of the PSW is negotiated and determined with respect to the client (e.g., PSWs can adopt a more passive and assistive role for people with physical disabilities, or a more active and decision-making role for people with dementia). Given the critical roles these workers play in Canada's health and social systems, they should be better recognized and better compensated for the work they do. Furthermore, robust research will be needed to gain a deeper understanding of the individuals who comprise this workforce, their scope of practice and the challenges they face.

## ACKNOWLEDGEMENTS

The CHW portion of this chapter is derived from work supported by the Population Health Improvement Research Network (PHIRN) through funding provided by the Ontario Ministry of Health and Long-Term Care, Funding Agency Ref. No. 06548, and by the Canadian Institutes of Health Research (CIHR) Institute of Gender and Health Doctoral Awards program.

The PSW portion of this chapter is derived from work supported with funding from the Government of Ontario through the Bruyère Centre for Learning, Research and Innovation in Long-Term Care.

The views expressed in this publication are the views of the authors and do not necessarily reflect those of the Province of Ontario.

Data and information on the provinces of Nova Scotia and Alberta were provided by Audrey Kruisselbrink and Greg Huyer, respectively.

## ACRONYMS

| | |
|---|---|
| ACCC | Association of Canadian Community Colleges |
| CACCE | Canadian Association of Continuing Care Educators |
| CCA | Continuing Care Assistant (Nova Scotia) |
| CHR | Community health representative |
| CHW | Community health worker |
| CHWNC | Community Health Worker Network of Canada |
| CPNP | Canada Prenatal Nutrition Program |
| CUPE | Canadian Union of Public Employees |
| DSW | Developmental support worker |
| GED | General Educational Development |
| HCA | Health Care Aide (Alberta) |
| HPRAC | Health Professions Regulatory Advisory Committee |
| HRSA | U.S. Department of Health and Human Services – Health Resources and Services Administration |
| LPN | Licensed practical nurse |
| MTCU | Ministry of Training, Colleges, and Universities |
| NIICHRO | National Indian & Inuit Community Health Representatives Organization |
| OCSA | Ontario Community Support Association |
| PSW | Personal support worker |
| PSNO | Personal Support Network of Ontario |
| PHAC | Public Health Agency of Canada |
| RPN | Registered practical nurse |
| WHO | World Health Organization |

## REFERENCES

(ACCC & CACCE) Association of Canadian Community Colleges & Canadian Association of Continuing Care Educators (2012). *Canadian educational standards for personal care providers: A reference guide.* Retrieved from http://accc.ca/wp-content/uploads/2014/05/Canadian-Standards-Reference-Guide.pdf.

Andrews, J.O., Felton, G., Wewers, M.E., & Heath, J. (2004). Use of community health workers in research with ethnic minority women. *Journal of Nursing Scholarship, 36*(4).

Armstrong, P., & Armstrong, H. (2010). *The Double ghetto: Canadian women and their segregated work* (3rd ed.). Don Mills: Oxford University Press.

Armstrong, P., Armstrong, H., Banerjee, A., Daly, T., & Szebehely, M. (2011). Structural violence in long-term residential care. *Women's Health and Urban Life, 74*(3), 390–399.

Armstrong, P., Armstrong, H., & Scott-Dixon, K. (2008). *Critical to care: The invisible women in health services*. Toronto: University of Toronto Press.

Atanackovic, J., & I.L. Bourgeault. (2014). *Economic and social integration of immigrant live-in caregivers in Canada*. IRPP Study 46. Montreal: Institute for Research on Public Policy.

Balcázar, H.G., Rosenthal, L., Brownstein, J.N., Rush, C.H., Matos, S., & Hernandez, L. (2011). Community health workers can be a public health force for change in the United States: Three actions for a new paradigm. *American Journal of Public Health, 101*(12), 2199–2203.

Bourgeault, I., Atanackovic, J., LeBrun, J., Parpia, R., Rashid, A., & Winkup, J. (2009). The role of immigrant care workers in an aging society: The Canadian context and experience. Ottawa: University of Ottawa.

Brookman, C.A. (2007). *The personal support worker improving work experience: A comparison across two health care sectors*. (Doctoral degree), University of Toronto, Toronto. Available from Thesis Canada National Archives Library database.

(CHWNC) Community Health Worker Network of Canada (2014 ). Position memo: *Community health workers – Canada's hidden workforce*. Submitted to the Canadian Public Health Association.

Calliste, A. (2000). Nurses and porters: Racism, sexism and resistance in segmented labour markets. In A. Calliste, G.J.S. Dei & M. Aguiar (Eds.), *Anti-racist feminism: Critical race and gender studies* (pp. 143–164). Halifax: Fernwood.

(CUPE) Canadian Union of Public Employees (2012). Personal support worker (PSW) registry notice to health care members of CUPE Ontario and OCHU. Retrieved from http://www.cupe.on.ca/a4938/CUPE%20OCHU%20letter.pdf.

Daly, T., Banerjee, A., Armstrong, P., Armstrong, H., & Szebehely. M. (2011). Lifting the "violence" veil: Examining working conditions in long-term care facilities using iterative mixed methods. *Canadian Journal on Aging, 30*(2), 271–284.

Dedam-Montour, D. (2010). Experiences of community health representatives in Canada. Personal communication. August 2010.

Denton, M., Zeytinoglu, I., Davis, S., & Hunter, D. (2006). The impact of implementing managed competition on home care workers' turnover decisions. *Healthcare Policy, 1*(4), 106–123.

Denton, M., Brookman, C., Zeytinoglu, I., Plenderleith, J., & Barken, R. (2015). Task shifting in the provision of home and social care in Ontario, Canada: implications for quality of care. *Health & Social Care in the Community*, 23(5), 485-492.

Federal Register. (2009). *Part VI: Office of Management and Budget 2010 Standard Occupational Classification (SOC)—OMB's Final Decisions; Notice Vol. 74, No. 12*. Retrieved from http://www.bls.gov/soc/soc2010final.pdf.

Findley, S.E., Matos, S., Hicks, A.L., Campbell, A., Moore, A., & Diaz, D. (2012). Building a consensus on community health workers' scope of practice: Lessons from New York. *American Journal of Public Health, 102*(10), 1981–1987.

Ghorayshi, P. (2002). Working Canadian women: Continuity despite change. In V. Dhruvarajan & J. Vickers (Eds.), *Gender, race, and nation: A global perspective* (pp. 123–146). Toronto: University of Toronto Press.

Government of Ontario. (1991). *Regulated Health Professions Act*. Retrieved from http://www.health.gov.on.ca/en/pro/programs/hhrsd/about/rhpa.aspx.

(HPRAC) Health Professions Regulatory Advisory Council. (2006). *The regulation of personal support workers* (Final report to the Minister of Health and Long Term Care). Toronto: HPRAC. Retrieved from http://www.hprac.org/en/reports/resources/PSW-FinalReportSept27-06.pdf

HRSA. (2007). Community Health Worker National Workforce Study. Retrieved from http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf.

Jezewski, M.A. (1995). Evolution of a grounded theory. *Advances in Nursing Science, 17*(3), 14–30.

Keefe, J., Martin-Matthews, A., & Légaré, J. (2011). *Home support workers: Human resource strategies to meet chronic care needs of Canadians: Final Report*. Retrieved from http://www.cdnhomecare.ca/media.php?mid=2798.

Kelly, C. (2016). *Disability politics and care: The challenge of direct funding*. Vancouver, BC: UBC Press.

Kelly, C., & Bourgeault, I. (2015a). Developing a common education standard for personal support workers in Ontario. *Health Reform Observer - Observatoire des Réformes de Santé, 3* (1),1-10.

Kelly, C., & Bourgeault, I. (2015b). The Personal Support Worker Program Standard in Ontario: An alternative to self-regulation? *Healthcare Policy, 11(2)*, 20-26.

Labonté, R. (1993). *Health promotion and empowerment: Practice frameworks* [Promotion Series #3]. Toronto: Centre for Health Promotion, University of Toronto and ParticipACTION.

Laporte, A., & Rudoler, D. (2013). Assessing Ontario's personal support worker registry. *Health Reform Observer, 1*(1), 1–11.

Lehmann, U., & Sanders, D. (2007). *Community health workers: What do we know about them? The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers*. Retrieved from http://www.who.int/hrh/documents/community_health_workers.pdf.

Lewin, S., Munabi-Babigumira, S., Glenton, C., Daniels, K., Bosch-Capblanch, X., van Wyk, B.E., … Scheel, I.B. (2010). Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases. *Cochrane Database of Systematic Reviews*. Retrieved from http://summaries.cochrane.org/CD004015/the-effect-of-lay-health-workers-on-mother-and-child-health-and-infectious-diseases.

Lewis, N., & Craig, C. (2014). *Institute for healthcare improvement summary report: 90-day project. Non-traditional workforce in today's health care*. Cambridge, MA: Institute for Health Care Improvement. Retrieved from http://www.ihi.org/about/Pages/default.aspx.

Lilly, M. B. (2008). Medical versus social work-places: Constructing and compensating the personal support worker across health care settings in Ontario, Canada. *Gender, Place and Culture, 15*(3), 285–299.

Lum, J. (2013) *Ontario PSW registry data analysis results*. Retrieved from http://www.ryerson.ca/crncc/knowledge/events/pdf/PSW%20Registry%20Data%20Analysis%20Results%20Final.pdf.

Mansell D., & Dodd, D., (2005). Professionalism and Canadian nursing. In N. Rousseau, D.E. Dodd & C. Bates (Eds.), *On all frontiers: Four centuries of Canadian nursing* (pp. 197–212). Ottawa: University of Ottawa Press.

Martinez, J., Ro, M., William Villa, N., Powell, W., & Knickman, A. R. (2011). Transforming the delivery of care in the post–health reform era: What role will community health workers play? *American Journal of Public Health, 101*(12), e1–e5.

Ministry of Health and Long-Term Care. (2011). *Ontario creating registry for personal support workers*. Retrieved from http://news.ontario.ca/mohltc/en/2011/05/ontario-creating-registry-for-personal-support-workers.html.

Ministry of Health and Long-Term Care (2014). *Improving home and community care for Ontario workers*. Retrieved from http://news.ontario.ca/mof/en/2014/04/improving-home-and-community-care-for-ontario-seniors.html.

Multicultural Health Brokers Co-operative. (2004). *Multicultural Family Connections Program: Mapping the life experiences of refugee and immigrant families with preschool children*. Edmonton: Author.

Najafizada, M., Bourgeault, I., Labonte, R., Packer, C. & Torres, S. (2015). Community health workers: A scoping review of HICs. *Canadian Journal Of Public Health*, 106(3), e157-e164.

(NIICHRO) National Indian & Inuit Community Health Representatives Organization. (2008). Closing of CHR Trust. *In Touch Newsletter, 33*(Summer). Retrieved from http://www.niichro.com/2004/pdf/intouch-summer-2008.pdf.

(OCSA) Ontario Community Support Association (2009a). *The history and development of the personal support worker and personal attendant in Ontario*. Retrieved from http://www.psno.ca/uploads/1/0/1/9/10197937/psw_history.pdf.

(OCSA) Ontario Community Support Association (2009b). *Role of persons trained as personal attendants or personal support workers*. Retrieved from http://www.psno.ca/uploads/1/0/1/9/10197937/psw_roles.pdf.

Ortiz, L. M. (2003). *Multicultural health brokering: Bridging cultures to achieve equity of access to health*. Unpublished doctoral dissertation, University of Alberta, Edmonton. Available from University of Ottawa Thesis and Dissertations (ProQuest) database.

(PHAC) Public Health Agency of Canada. (2010). *Summative evaluation of the Canada Prenatal Nutrition Program, 2004–2009*. Retrieved from http://www.phac-aspc.gc.ca/about_apropos/evaluation/reports-rapports/2009-2010/cpnp-pcnp/overview-ve-eng.php#a2.

(PSNO) Personal Support Network of Ontario (n.d.) *Frequently asked questions*. Retrieved from http://www.psno.ca/faqs.html.

(PSNO) Personal Support Network of Ontario. (2014). *What can a PSW do? Role of personal support workers and area of ability*. Retrieved from http://www.psno.ca/uploads/1/0/1/9/10197937/what_can_a_psw_do_fs_2014.pdf.

Richardson, S. (2005). Unionization of Canadian nursing. In N. Rousseau, D.E. Dodd & C. Bates (Eds.), *On all frontiers: Four centuries of Canadian nursing* (pp. 213–224). Ottawa: University of Ottawa Press.

Rodrigues Fausto, M.C., Giovanella, L., Magalhaes de Mendonca, M.H., Fidelis de Almeida, P., Escorel, S., Tavares de Andrade, C.L., & Carsalade Martins, M.I. (2011). The work of community health workers in major cities in Brazil: Mediation, community action, and health care. *Journal of Ambulatory Care Management, 34*(4).

Rootman, I., Goodstadt, M., Hyndman, B., McQueen, D. V., Potvin, L., Springett, J., & Ziglio, E. (Eds.). (2001). *Evaluation in health promotion: Principles and perspectives* (Vol. 92): WHO Regional Publications.

Saari, M., Patterson, E., Kelly, S., & Tourangeau, A. E. (2018). The evolving role of the personal support worker in home care in Ontario, Canada. *Health & Social Care in the Community*, 26(2), 240-249.

Servage, L. (2008). *The shadowy world of private tertiary providers in Canada: Buyer beware?* Paper presented at Perspectives on Labour Shortages: Exploring the Education-Jobs Gaps, University of Alberta, Edmonton, Alberta, Oct. 24, 2008.

Sutherland, J.M., & Crump, R. T. 2011. Exploring alternative level of care (ALC) and the role of funding policies: An evolving evidence base for Canada. *CHSRF Series of Reports on Costs Drivers and Health System Efficiency 8*. Retrieved from http://www.cfhi-fcass.ca/SearchResultsNews/11-09-20/29f5b70f-e94f-4986-9455-231888e40f4a.aspx.

Torres, S. (2010). *Uncovering the role of community health worker/lay health programs (CHWs/LHWs) in addressing health equity for immigrant women in Canada*. Unpublished research conducted as part of the authors' doctoral program, University of Ottawa, Ottawa.

Torres, S. (2012). *Environmental scan on personal support workers/lay health workers involved in homecare and long-term care in Ontario: A rapid literature review*. É/Exchange Working Paper Series.

Torres, S. (2013). *Uncovering the role of community health worker/lay health worker programs in addressing health equity for immigrant and refugee women in Canada: An instrumental and embedded qualitative case study*. University of Ottawa Thesis and Dissertations (ProQuest) database.

Torres, S., Labonté, R., Spitzer, D.L., Andrew, C., & Amaratunga, C. (2014). Improving health equity: The promising role of community health workers in Canada. *Healthcare Policy/Politiques de Santé*, 10(1), 71-83.

Torres, S., Balcázar, H., Rosenthal, L., Labonté, R., Fox, D. J., & Chiu, Y. (2017). Community Health Workers in Canada and in the US: Working from the Margins to Address Health Equity. *Critical Public Health*, doi:10.1080/09581596.2016.1275523.

Werner, D. (1977). *Where there is no doctor*. Palo Alto, CA: The Hesperian Foundation.

Werner, D., & Bower, B. (1982). *Helping health care workers learn*. Palo Alto, CA: The Hesperian Foundation.

Wodchis, W.P., Ceccato, N., Berta, W., Chambers, L., McGilton, K., & Tourangeau, A. (2007). Factors associated with personal support worker turnover in Ontario LTC homes. Retrieved from http://www.ihpme.utoronto.ca/Assets/IHPME+Digital+Assets/IHPME/hpme/research/hsr/ltc-ww-2007/psw.pdf.

Wolfe, R. (2010). *Working (in) the gap: A critical examination of the race/culture divide in human services*. (PhD), Unpublished doctoral dissertation, University of Alberta, Edmonton. Retrieved from http://proquest.umi.com.proxy.bib.uottawa.ca/pqdweb?did=764801241&Fmt=7&clientId=65345&RQT=309&VName=PQD. Available from University of Ottawa Thesis and Dissertations (ProQuest) database.

(WHO) World Health Organization Commission on the Social Determinants of Health. (2005). *Action on the social determinants of health: Learning from the previous experiences* (C. o. S. D. o. Health, Trans.). Geneva: Author.