Relations between Immigrant Care Workers and Older Persons in Home and Long-Term Care*

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RÉSUMÉ
Les aidants immigrés jouent un rôle de plus en plus important dans les soins de domicile et les soins de longue durée au Canada, mais l'ampleur totale de leurs relations avec les personnes âgées dans ces cadres est relativement inconnue. Cet article examine le rôle des aidants immigrés dans les deux secteurs de domicile et de soins de longue durée, mettant l'accent sur les relations avec les anciens et les implications pour la qualité des soins. Les données proviennent des entrevues avec les travailleurs, les employeurs et les clients anciens menées dans divers services d'accueil et de soins de longue durée pour personnes âgées dans trois provinces canadiennes: l'Ontario, la Colombie-Britannique et le Québec. Les facteurs qui découlent des origines ethniques ou raciales des aidants immigrés, barrières linguistiques et facteurs contextuels tels que la pénurie de personnel en soins de différents paramètres pour les personnes âgées compliquent la relation entre les aidants immigrés et leurs clients. Dans certains cas, ces facteurs diminuent la qualité des soins. Nous indiquons quelques politiques alternatives que nos conclusions suggèrent devraient être considérées.

ABSTRACT
Immigrant care workers play an increasingly important role in home and long-term care in Canada, yet the full extent of their relations with older persons in those settings is relatively unknown. This article examines the role of immigrant care workers in both home and long-term care sectors, with a focus on relations with older clients and implications for quality of care. The data are derived from interviews with workers, employers, and older clients conducted in various home and long-term care services for older adults across three Canadian provinces: Ontario, British Columbia, and Quebec. Factors stemming from immigrant care workers' ethnic/racial background, language barriers, and contextual factors such as staff shortage in different care settings for older adults complicate the relationship between immigrant care workers and their clients. In some cases, these factors diminish the quality of care. We point to some policy alternatives that our findings suggest should be considered.

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Introduction

Canada is experiencing a shortage of care workers, particularly in the home and long-term care sector, and this is expected to become that much more acute with the aging of the population and the parallel aging of care workers (Canadian Institute for Health Information [CIHI], 2007; Statistics Canada, 2007). There have been several responses to these current and projected shortages of care workers including tapping into the existing resource of immigrant care workers (Bourgeault, 2008; CIHI). The use of immigrant workers not only has implications for the workers themselves and, some would also argue, for the countries these workers arrive from (Kapur & McHale, 2005), but there are also important implications for those needing care here and for the quality of care provided. The full extent of the roles immigrant care workers play in the delivery of care in the context of an aging Canadian society is, however, relatively unknown. Knowledge about the relations between immigrant care workers and older adult clients is particularly limited. Given our relative dependence on immigrant workers in health care, these are alarming gaps in our knowledge.

It is our aim, in this article, to examine the role of immigrant care workers in the home and long-term care sectors in Canada, with a particular focus on the relations with older adults and the implications for quality of care. The article draws on data taken from a study largely based on interviews with workers, employers, and older adult clients conducted in various home and long-term care sectors across three Canadian provinces: Ontario, British Columbia, and Quebec. Our analysis of these data reveal important insights with regard to how both the factors stemming from an immigrant's ethnic/racial background, cultural differences, and language barriers complicate the relationship between these care workers and their clients. Where they work – home versus long-term care – is also influential on relations between older adult clients and their care workers. On the basis of these findings, we highlight the complexities in the role of immigrant carers in the provision of care in the Canadian care sector for older adults and point to the policy implications suggested by our findings.

Relations between Older Adults and Care Workers and the Role of Race/Ethnicity

The relationship between older adults and care workers is an issue of growing interest among health and social science scholars. Because older adults typically suffer from multiple chronic illnesses, their care is much more complex than typical clinical care. Further, heterogeneity amongst patients is greatest among the old, not just in terms of demographic characteristics but also in terms of physiological and pathological processes, which makes standardization and routinization of procedures more difficult and less efficient (Barker, 1994). Given the complexities in older adult care, a number of studies have examined how this affects the relationship between health care providers and older patients (Aronson, 2004; Fineman, 1991; Hasselkus, 1992; Haug & Ory, 1987; Iecovich, 2000; Martin-Matthews, 2007; Neysmith & Aronson, 1997).

In early studies, the focus was typically on older patients' relations with their physician, where ageist attitudes were found to be prevalent (Haug & Ory, 1987). More recent research has focused on a range of professional and non-professional care workers in home and long-term care where there is said to be a more collaborative sharing of control and responsibilities (Aronson, 2004; Iecovich, 2000; Martin-Matthews, 2007). The reasons and circumstances that might invoke conflicts and tension between older adults and the staff in various institutional settings include personal characteristics and cultural background, psychological reactions, division of tasks, dissatisfaction with care provided to older adults, type of setting, and facility's regime and policies (Iecovich). The situation of home care is further complicated by the symbolic significance of an older person's home: it was theretofore private spaces that have become, to a certain extent, public through the provision of support services (Martin-Matthews). Across both settings, there is a tension between balancing institutional and agency prerogatives and the needs of older adult clients. Indeed, the interaction between care workers and older adults is arguably shaped by both the groups' lack of power in the home and long-term care systems (*c.f.,* De-Ortiz, 1993). Clearly, the quality of interpersonal relations, however, has an unequivocal impact on the patient's experience in debilitating conditions; a fact that has been underscored in several studies (Jacelon, 1995; Kaufman, 1988; Nolan, Grant, & Nolan, 1995).

The issue of relationship between older adults and care workers becomes even more complex when care workers are immigrants, particularly those who are visible or racial minorities. Cultural values and assumptions about life, modes of social interactions, behavioural norms, and practices are significantly influenced by race and in turn affect health beliefs and actions (Bates, Rankil-Hill, & Sanchez-Ayendez, 1997; Cooper & Roter, 2003; Shaw, 2005). It has been well-established that similarities in different cultural characteristics between the patient and care providers improve the quality of care and facilitate good relations. Similarities in ethnic origin, religion, and language mean patient and care provider are more likely to hold similar beliefs, values, speak the same

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language, and understand each other better (Barker, 1994). Patients seeing physicians of their own race, for example, have been shown to rate their physicians' decision-making styles as more participatory (Cooper-Patrick, 1999).

On the other hand, disparate and incongruent beliefs with respect to health and illness by professional staff and patients can lead to communication difficulties, misunderstandings, and conflict (Fineman, 1991). Most of the research in this domain focuses on patients of different ethnic backgrounds exploring issues related to the communication patterns between care provider and patients (Cooper & Roter, 2003; Frank, 2000; Gerrish, 2001; Lyons, O'Keeffe, Clarke, & Staines, 2008; Pauwels, 1995; Wish Garrett, Roberto-Forero, Grant Dickson, & Klinken Whelan, 2008). Given the increasing number of minority patients, the provision of a culturally competent carer is considered one of the key strategies for reducing racial and ethnic health disparities (Brach & Fraserirector, 2000; Institute of Medicine, 2004; Josipovic, 2000; Shaw, 2005). Policy makers also call for the recruitment of ethnic minority providers to care for minority groups (Institute of Medicine), although the idea of ethnic resemblance has been criticized by some (Shaw). It is important to emphasize in this context that cultural misunderstanding does not belong to or stem from either patients or providers but rather incongruity comes from *the interactions* between the two (Barker, 1994).

Much less attention has been given to the race/ethnic diversity among the care providers and how that shapes their relations with patients. Yet the issue is becoming increasingly significant in many countries, including Canada, where assisting or ancillary occupations in health care are disproportionally filled by immigrants and people from racial minority groups (Armstrong, Armstrong, & Scott-Dixon, 2008). Denton, Zeytinoglu, and Davies (2002), for example, found that 43 per cent of home support workers in their study sample were born outside Canada, a figure much higher than in the population for that city (Hamilton) or the country as a whole, which is 16 per cent according to the 2006 Census of Canada.

The issue of cultural competency becomes even more critical because care workers from racial and visible minority groups provide services to a whole range of older adults in different care settings, which entails significant adjustment and accommodation on the part of the care providers. Care workers are expected to be able to have a range of complex communication skills, use and interpret body language, master technical and academic discourse, and possess colloquial interpersonal skills. They face demanding social and linguistic realities that entail a greater level of accommodation in terms of overcoming communication and technical barriers and impairments (*c.f.,* Duff, Wong, & Early, 2000).

Moreover, like minority patients, racial/visible minority migrant care workers vary in terms of their perceptions and beliefs about care. In one study of migrant workers in the U.K., it was found that respect and discipline are central to the workers' construction of care, and were closely tied up with understandings of age and generation (Datta, McIlwaine, Evans, Herbert, May, & Wills, 2006). The study showed that many migrant workers from sub-Saharan Africa had a veneration of age that was rooted in the cultures of their home nations. Many care workers from certain cultures created nurturing relationships with their clients that went beyond the simple provision of care. In one study of migrant women taking care of older adults at home, Spitzer, Neufeld, Harrison, Hughes, & Stewart (2006) found that women from South Asian and Chinese origins felt that women were the most appropriate caregivers for older adults as well as children. These issues only provide us some insights about how cultural orientations may influence the relationship between racial or visible minority care providers and older adults.

The literature also provides some ideas about how relationships with older adults are shaped by different health care settings like hospitals, nursing homes, or home care, particularly the incidences of racial discrimination often faced by visible minority care workers from older adults and their families (Allen & Cherry, 2006). In a study investigating three nursing homes in Illinois, USA, Berdes and Eckert (2001) revealed that three quarters of the nurse's aides, mostly from racial minority groups, had experienced racism on the job from residents, family members of residents, and fellow staff. Similarly, Browne (1986) found that foreign-born immigrants are more likely to suffer malignant racism characterized by hurtful, intentional language based in long-standing prejudice than their American-born Black colleagues. There is also evidence in Canada of racism for higher-status occupations (e.g., Gupta's [1996] study, which documented the experiences of institutional racism faced by visible minority nurses). Similarly, a survey of personal support workers (PSWs) in unionized long-term care workplaces in Manitoba, Ontario, and Nova Scotia found that 11.7 per cent of the workers encountered racist comments on a daily or weekly basis (Banerjee, Daly, Armstrong, Armstrong, Lafrance, & Szebehely, 2008). It was observed, however, that visible minorities, who comprise a higher proportion of the personal support staff in large urban centres, are very likely to experience a higher incidence of racism than those reported in the study.

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Racism, it has been argued, can be a bigger problem for visible minority health workers engaged in non-professional or ancillary services than those who work as professional nurses. According to Armstrong et al. (2008), the parallels between home care and domestic service reveal how racism unfolds in home-based care work in ways it does not in institutionally based care work where workers at least have some protection enabled through organizational structures (see also Jönson, 2007). Neysmith and Aronson (1997), for example, demonstrated how the racialized nature of home care work plays out at the microlevel of daily service provided within older adults' homes. In-depth interviews and focus groups revealed that workers deal daily with racist attitudes and behaviours from clients and their families. The study also documented the different mechanisms through which the workers deal with racism such as avoidance, incidents within an analysis of the circumstances of older adults, setting boundaries on discussions, and occasionally, confrontation. Although it is evident that experiences of racism exist in different types of health care settings, it is less clear how these settings compare in terms of moderating the relationship between older adults and visible minority care worker.

In sum, with some exceptions, there is a significant gap in our understanding the role of ethnicity/race in microprocesses of the interaction between these workers and clients in different care settings. Against this backdrop, the focus of this study was motivated by the premise that the occupational, cultural, social, and linguistic processes experienced by immigrant care workers require a higher level of interaction with older adults that, in turn, may have important implications for their relationship and, also, for the quality of care given and received in such settings. Equally important in this context is to take account of the patients' perceptions about the ethnic background, cultural traits, language skills, and health care practices of the providers. Accordingly, these previously under-researched processes represent a fascinating and relevant area of research.

The Immigrant Care Worker Study

This article presents data from a larger, international comparative study of the experiences of immigrant care workers, employers, and older adult care recipients in a range of different health care institutions and private households in three provincial contexts: Hamilton/Toronto, *Ontario*; Vancouver/Victoria, *British Columbia;* and Montreal, *Quebec*. In each location, care was taken to purposively sample workers and employers from large and small institutional settings, from home care services, and from private households. In the case of workers, our aim was to achieve maximum variability in their background, so we targeted economic migrants, including those who came through the Live-In Caregiver program,[1] as well as those who came to Canada as refugees. Across these categories, we also strove to secure interviews with care workers from a range of ethnic backgrounds, fully appreciating that many immigrant care workers come from the Philippines. We also included a range of professional and non-professional categories from registered and practical nurses to personal support workers. In the case of older adults, we purposively sampled both current and future care recipients (i.e., older adults not presently in care). We secured interviews with 77 workers, 24 employers, and 29 current and future care recipients (hereafter referred to as older adults) across the different sites (see Table 1). These final numbers reflect when the team of interviewers reached a point of saturation in each province in terms of the key comparator categories noted in the aforementioned purposive sampling strategy.

All of the interviews were semi-structured, which provided an opportunity for interviewers to explore attitudes, experiences, and interpretations with the different participants.[2] Interviews with workers explored three topic areas: (1) their reasons for and means of migration; (2) choice of employment, working, and living conditions; and (3) issues related to turnover, aspirations, and social integration. Interviews with employers and human resource managers similarly examined three topic areas: (1) the demand for and experiences with immigrant labour; (2) factors affecting quality of care; and (3) the client/worker relationship. Interviews with current care recipients of home and long-term care services focused on their experiences with these services and with immigrant care workers. Interviews with future care recipients focused on their preferences with respect to the type of care they would

Table 1: Study participants by province and category

Provinces	Workers	Employers	Current Recipients	Future Recipients	TOTALS
British Columbia	24	12	6	7	49
Ontario	34	6	3	5	48
Quebec	19	6	3	5	33
TOTALS	77	24	12	17	130

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like to receive (homecare, nursing home, etc.) as well as their opinions on accepting care by immigrant care workers. All interviews took place in a setting of the respondent's choice and were conducted primarily in person, but for logistical reasons some were conducted by telephone. All interviews were taped and later transcribed verbatim with participants' approval.

The analysis of the interview transcripts was aided with the NUDIST qualitative data analysis software program. A preliminary comparative coding scheme was developed jointly by our international research team (including scholars in the U.S., the U.K., and Ireland) and subsequently applied using this program to relevant segments of the interviews by four research assistants – three for the English interviews with workers, employers, and care recipients, and one for the French interviews across the three participant categories. Regular reliability checks through cross-coding of randomly selected transcripts were undertaken to ensure accurate and consistent coding of the data.

In this article, we draw primarily on the responses of the workers and care recipients. The key codes from the care workers include the qualities of a good carer, their own attitudes about older adult care, and their relations with older adults including any instances of experienced racism. With respect to older adult interviews, the codes that were used to determine characteristics of a "good carer" were divided into two parent codes: (1) personal qualities, and (2) acquired qualities. The "personal qualities" code included sub-codes such as culture of care, personality, commitment, and so on, and the "acquired qualities" code captured sub-codes such as language, communication skills, and Canadian cultural competency. The codes used to assess the attitudes of current and potential care recipients towards immigrant care workers included language, cultural competency, credentials, and training.

The Characteristics of a Good Carer

Both immigrant care workers and older adults agreed as to what makes a good carer. Both groups described a good carer as one who is patient, compassionate, and capable of understanding and responding to the needs of his or her patients. Being willing to take the time to talk with and listen to older persons was echoed by several of our participants. It was also important to some that a carer be trustworthy especially if they were going to work in their homes. Others noted how one must be committed to his or her job, willing to work as a team member, and willing to constantly upgrade his or her training in order to provide the best possible care to older adults. Many workers drew satisfaction from providing good care despite feeling their job was not necessarily the best:

> *Of course this is not the best job. You can imagine how that is. But if you are doing that with respect, trying to respect the dignity of this person, you are doing a good job and these people feel that. (Care worker, Ontario)*

In addition to the above characteristics that pertain to all care workers, many older adults felt that a characteristic of a good carer unique to immigrant care workers was having competency in Canadian culture. Several older adults mentioned that immigrant care workers need to understand Canadian culture before they should care for older adult Canadians. These respondents expressed that immigrant care workers are sometimes unable to relate to the Canadian way of caring because of a cultural difference. It was also noted that every culture is different, hence, immigrant care workers must learn to adapt to the culture of the country in which they work. Commenting on this issue, one of our respondents noted how immigrant care workers' understanding of her needs might have been affected by the culture they came from:

> *In the small details like not knowing how to, you know, how to do some of the household things. You know, not sort of having a clue about how to make a meal the way we wanted it which I would have thought they'd have been taught. (Older adult, Ontario)*

One respondent who worked in more than one care setting introduced the notion of flexibility and adaptability to the list of good carer qualities.

Types of Relationships between Immigrant Care Workers and Older Persons

We teased apart three types of relationships between immigrant care workers and the older people they care for: (1) a "professional relationship" characterized by a clearly identified border between client and carer somewhat devoid of any emotional attachment; (2) a "friendly relationship" marked by friendship between client and carer (developed usually in home care settings and in live-in caregiver situations); and (3) a "discriminatory relationship" described by respondents as the one that includes verbal abuse from clients on the basis of carer's skin colour, accent, and language difficulties.

When some immigrant care workers were asked whether they had developed a sense of companionship with their clients, some described a more professional relationship:

> *I would like to be more [on] a professional level. I don't want to be close and I don't want to … like, we are really good but I don't want to go any further. (Care worker, Ontario)*

From the clients' perspective, this kind of detachment albeit professional was regarded with some disdain:

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Physically they're rougher with you … with me. I feel bad saying that but yeah, I find that they're physically much rougher. They will come in the room and not say a word and just grab your arm and start doing an IV. That kind of thing, where there's no caring. … It's just, "get the job done". (Older adult, BC)

By way of contrast, some immigrant care workers felt comfortable developing very friendly relations with their older adult clients. This was particularly true for those either in or from the live-in caregiver program:

Friendship, yes. And if we're lucky they treat us like their granddaughter too. Yeah, we have some clients like that. And their family also, they treat us like their relatives. (Care worker, Ontario)

They treat me like a daughter, like family: that's what we want. (Care worker, Quebec)

Similarly, interviews with older adults revealed how they had pleasant relationships with their immigrant care workers. They talked about their care worker being friendly, helpful, and willing to go above and beyond their duties to make sure that they were satisfied. Some older adults pointed out how informal communication between the care worker and themselves is important because older adults can get lonely. One of the older adults we interviewed described a particularly good carer as follows:

I have a caregiver that lives right in this room. She is very empathetic. She's a caring lovely person, and the lengths she goes to for some of her clients is to the nth degree. She really, truly does. She stayed up with an 82-year-old man because he was very, very ill. He had no family. And he thought of her as family so she stayed with him until he passed away. That's what I call a kind of devotion. (Older adult, BC)

Lastly, interviews showed that although immigrant carers were generally treated with respect and dignity by their older adult clients, racism did play a part in their working experiences. Some participants (especially those who self-identify as visible minorities, coming from Africa or the Philippines) reported that they experienced a high level of discrimination, based on their skin colour, by older adults. Specifically, these workers stated that due to their skin colour, they were often looked down on and in some instances verbally attacked by clients. Recalling such experiences, two workers described:

Yeah. I have experienced that with my residents. One of my residents in the other job was Italian. And I think he is a racist. Every time a black caregiver or staff came over to his room he said "Go to hell. I don't want you. I don't want black people." So he is racist. (Care worker, Ontario)

But some ladies don't want … a black woman for example and they say that: "Oh I don't like that black woman." That's really frustrating because she can be the best person, she can be the best worker, and – just because she is black. Once I heard in that nursing home they don't like the Philippine people. [But] They are great. They are really hard workers. What's the problem? Always there are people like that. (Care worker, Ontario)

Some of the older persons we interviewed mentioned that some immigrant care workers are better care workers because their cultures foster a more positive attitude to caring for older adults. This was noted in particular with regard to Filipino care workers. Explaining this issue further, one older man we interviewed said:

You have different characters in every nationality. You know, you take like Filipinos, they're very soft people, very caring people. (Older adult, Quebec)

Many respondents felt that some immigrant care workers were more caring because they had been trained to do that all their lives with their families. As one interviewee pointed out:

I did notice that the people that were from abroad, in particular the people that we had come in from like the Philippines, I noticed that … culturally, … they have a little bit different attitude towards the elderly. The whole families look after them. … I've lived in the Philippines as well and I've seen how their care system works and the whole families look after elderly. And I don't even think I saw one care facility the whole time I lived in the Philippines. (Older adult, BC)

A few respondents also mentioned that they think that some immigrant care workers are much more committed to their job because they come to Canada to pursue a better life, and one way to get a better life is through working hard in one's job. Some, however, said that Canadian-born care workers were more committed to their jobs:

Some of them – [it was] like they didn't want to be care aides. They just wanted to be in Canada and this was the way to do it. Two of them were civil engineers [in their home country] – you know: they were not doing the job [in Canada] they wanted to do and so therefore they weren't doing it well. Then again, one of them who was the most physically cruel had worked for decades in a Canadian hospital somewhere. (Older adult, BC)

Some of the older people we interviewed also expressed concern about the quality of education and training of immigrant workers:

A young immigrant worker doesn't have the same understanding of how it feels when you get turned

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over and the tube is being yanked the wrong way or – you know? They don't have the same training or the same care. I don't know what it is, but it's just not there." (Older adult, BC)

So clearly there were a range of perspectives both on the side of the workers and on the side of older adults concerning the kinds of relationships they had with each other. In both sets of interviews, we wanted to understand further what influenced these types of relationships and what impact this had on the quality of care.

Factors Influencing the Types of Relationship and Quality of Care

The quality of the relationship between carers and clients and the quality of care in turn is affected by a range of issues – some particular to immigrant care workers, whereas some are reflective of broader issues endemic to the home and long-term care sectors. In addition to the cultural competency issues we have mentioned, a particular challenge for care workers and older persons is related to language sufficiency. In particular, many of the older adults we spoke to felt that it was of utmost importance for care workers to have a minimum of English (or French in the case of Quebec) language proficiency. They also felt that it was important for the carer to understand what the older person needed because if they did not, it could cause errors that could possibly cause death:

There was just one situation where the woman didn't really, [well,] her English wasn't very good and [it] happened she was only on the job for about one week and my father had a minor heart attack, and she didn't know what had happened and … I kind of asked her what had happened … and she couldn't really understand me. (Older adult, BC)

How language barriers, including accent, influence the quality of the relationship between carers and clients and, in turn, the overall quality of care, was also salient in the worker interviews:

I have had some difficulties at the beginning because my English was very poor once I came to Canada. Now I feel pretty much okay because my clients, they understand me. They don't feel any difficulties to understand me to see what I want, to see what I want for them, and to understand them so now it's pretty much okay. (Care worker, Ontario)

Care worker: Sometimes some people are very particular with the accent.

Interviewer: Okay. Do they complain about your accent?

Care worker: Yeah, they will tell you "I don't understand you." (Ontario)

Given the multicultural make-up of the Canadian population, including older adults in home and long-term care, these language barriers can go both ways – not only on the part of care workers but also on the part of clients. For instance, reflecting on that, one of the workers noted:

Oh, there's a lot of them who doesn't speak English. It's a problem. Especially those who came from Europe or from the Asian countries. Some of them they don't speak good English so it's so difficult to deal with these kind of residents. (Care worker, Ontario)

A broader contextual factor that greatly influences the quality of the relationship and quality of care is beyond the issue of the racial and ethnic background of the care worker: it focuses squarely on the perceived shortages of staff in the home and long-term care sector. Describing how the shortage of staff in long-term care settings influences the interaction between workers and patients in one nursing home in which she is working, one respondent revealed:

In the nursing home you have more people, more patients, and usually you are short the staff. You have to rush your work. You don't have time to talk to the patients too much because you are rushing to finish everything. (Care worker, Ontario)

Many of the workers were able to compare the quality of care because they worked in more than one setting. Most claimed the quality of care to be higher in home care settings as the carer is fully devoted to only one patient.

Interviewer: Okay. What about working at home?

Respondent: Oh, it's different because it's my time. Just my client. And I don't need to rush because if I have one hour for him or her, I plan how can I do [everything] in one hour. But in the nursing home you have three hours for 20 clients. (Care worker, Ontario)

Some, however, expressed concern about the lack of backup or the presence of co-workers in home care situations, which they in turn felt influenced the quality of care they could provide. As one stated:

Quality of care in hospital is better. You know why? You have somebody to help you. In the home care if you are alone and your client falls down, you cannot ask for any assistance. (Care worker, Ontario)

Another respondent noted, however, that if one cannot recognize and respond to the needs of the patients due to workload, even workers with the highest level of competency and best intentions will not be able to have a positive impact on the quality of life of the patients.

Ou des fois on voit quelqu'un pleurant, et ont va dire… 'Madame, vos médicaments!' Et laisser ça. On

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les voit, et … qu'est-ce qui se passe? On doit parler un peu.

The times one sees somebody crying, and we do say … "Madam, your medication!" and leave it at that. They are seen, and … why does this occur? One can only say a little. (Care worker, Quebec)

It is here where the characteristics of good care, agreed upon by both care workers and older adults, were confronted by a context that did not permit for effective care to take place. Although working with older adults may have been particularly challenging for immigrant care workers and their clients because it did not enable the time necessary for their specific challenges, such as language and cultural differences, to be overcome, the staff shortages endemic to this care sector affects all care workers and older adult care recipients.

Discussion

Despite the fact that the Canadian health care sector increasingly relies on immigrant care workers as one of its solutions to labour shortages, our study found that the role of immigrant care workers in the home and long-term care sectors for older adults is complex. This complexity has its roots in the influences, from which the immigrant's ethnic/racial background, language, and cultural differences stem, have on the carer-client relationship. Some of the older adults experienced situations where immigrant care providers were not culturally competent in meeting their care needs. But it is not as though immigrant care workers have language and cultural challenges and older adult clients do not. Indeed, as we have noted, language and cultural barriers go both ways in the interaction. As Duff et al. (2000) have shown, immigrant care workers need to learn how to communicate with older adults who themselves do not speak English. Our findings are also in accordance with findings of other studies, which emphasize that language difficulties and cultural differences between patients and providers can have a significant influence on patients' perceptions of an immigrant provider's ability to offer adequate care and consequently on their relationship (Barker, 1994; Fineman, 1991; Jönson, 2007).

In drawing out the different types of relationship between immigrant care workers and the older people for whom they cared, we feel it is particularly important to emphasize the first two types of relationship: professional and friendly, reflective of a broader understanding of relations between immigrant carers and older adult clients and confirmed in some previous work (e.g., Iecovich, 2000). This is because the discrimination theme tends to dominate the literature and discrimination in a negative direction (with notable exceptions such as Datta et al., 2006). Some of the most interesting and illuminating insights offered by some of the older adults we interviewed are of the *positive* discriminatory comments, in that some immigrant care workers are better at providing older adult care because of their cultural backgrounds. These positive discriminatory views shed light on the broader role of racism in relations between clients and immigrant workers in Canadian care settings for older persons, which has not been sufficiently addressed by previous research.

Our finding that the shortage of staff, and general neglect of older adult care, compound the linguistic and cultural challenges of immigrant care workers and their clients reflects several studies that have attempted to highlight the difficulties faced in the home and long-term care sectors (e.g., Armstrong & Armstrong, 2002; Aronson, 2004; Denton et al., 2002). This finding also confirms other studies that have documented how health care reforms have a disproportionately negative effect on visible minority health workers, patients, and in turn their quality of care (Spitzer, 2004). Albeit with a different patient population (maternity care), Spitzer found that the shortage of staff brought by these reforms has significantly shortened the time nurses can devote to their patients, leaving the needs of many patients unmet, echoing the time constraints our immigrant care workers voiced.

All these insights have important policy implications. First, educational programs about relevant Canadian cultural issues particularly focused on older adults should be made available to immigrant care workers working in Canadian care settings for older adults. These could parallel the kind of pre-registration bridging programs available for internationally educated nurses, such as the CARE for nurses program in Ontario. Second, more anti-racist education and campaigns should be introduced to families and clients of home care and long-term care services paralleling the anti-violence campaigns that have been implemented in various health care settings. Retirement homes and seniors centres could also be broader targets for these efforts as these include potential future clients of these services. More situation-specific, conversational English or French language classes should be provided for immigrant care workers as part of the workplace introduction programme. Finally, employers could consider targeting certain immigrant care workers for older adult clients from similar backgrounds as a means of better matching language and cultural issues, similar to the policies implemented around aboriginal care workers for aboriginal communities.

Albeit informative, confirming some findings and extending others, our study is not without limitations. One of the key limitations was our inability to match the perceptions of workers and older adults that a dyadic approach could offer. Perhaps future research can attend to this limitation by working this purposively

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into their research designs. Other fruitful areas of exploration would be to purposively sample different older adults from different ethnic backgrounds to compare and contrast their perspectives on the role of, and their experiences with, immigrant care workers.

Notes

1 The Live-in-Caregiver Program (LCP) recruits domestic workers from foreign countries to work as live-in caregivers in Canada for a period of no fewer than 24 months. Their clients are also their immigration sponsors.

2 In three cases, interviews took the form of focus groups consisting of two to four workers each.

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