“Short-Term Band-Aid Solutions”:

A Feminist Analysis of Family Caregiving and Caregiver Immigration Policies in Canada

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Abstract

Throughout Canada, the need for care provision services is on the rise. The number of people willing and able to provide these care services is insufficient to address the growing need for care. Care work is provided by a mix of paid workers and unpaid family members. The majority of both these groups of care workers are women. Care work has long been undervalued as feminized labour, resulting in insufficient government support for family caregivers, and persistent labour issues within paid care sectors. In this thesis, I explore two distinct sets of Canadian federal policies related to care provision – Employment Insurance (EI) benefits for unpaid family caregivers, and the Home Child Care Provider and Home Support Worker Pilot Programs, which facilitate the immigration of private in-home caregivers to Canada – in order to discover whether they are underpinned by a shared set of similar assumptions about the nature of care work, who is best suited to perform it, and how it should be provided. In examining the assumptions about care that underpin and shape these policies related to care provision in Canada, I identify a number of consistent gendered themes about care and care providers and analyze their impact on policy outcomes.

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I recognize with respect the traditional territories of the lək̓ʷəŋən and WSÁNEĆ nations on which much of the research and writing of this thesis took place. I also recognize with respect the traditional territory of the Snuneymuxw nation, on which I live.

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Introduction, Theoretical Framework, Methods, and Literature Review

Introduction

Canada is in the midst of a care crisis. This care crisis, in large part, reflects the unsustainability of the social relations that currently structure the organization of care. At its most basic level, the care crisis can be understood in terms of demographics: the number of people who require care has increased at a much more rapid rate than the number of people who are able and willing to provide it (Glenn 2010, 1; Tronto 2015, 2). However, there is much more to this crisis. The care crisis encompasses a deeper set of problems that make care inaccessible to many who require it, and compromise safety, respect, and fair compensation for those who provide it. "Care" is a comprehensive term that can be used to describe a variety of social relations and practices. A broad understanding of care includes the whole range of activities individuals undertake every day to sustain their physical bodies, emotional and social needs, and the environments in which they live (Tronto 2015, 3). In contrast, policy debates and scholarship addressing care work tend to focus more narrowly on public or private services for young children (e.g. preschools, daycares) and facilities for the elderly or those with medical needs. For instance, a great deal of research has focused on challenges regarding the provision of elder and child care in many Global North countries, specifically in the context of cuts to the welfare state and the shortage of caregivers (see, for example Struthers 2013; Twomey 2013). Further, the dearth of affordable child care centres in Canada has also demanded research and policy attention in recent years.

Although public and private child care and elder care centres are important sites where care work takes place, they are not the only places where care happens. Indeed, care workers can be found washing linens in hospital laundry rooms, preparing meals at a local nonprofit food

program, driving elderly clients to a doctor's appointment, changing diapers for a sister's newborn baby, or holding the hand of a loved one who just received a troubling call from their doctor. Care work can be organized in a variety of ways: it can be paid or unpaid, it can take place inside or outside the home, it can be privately contracted or publicly funded, and it can be provided through a combination of modalities and funding structures. The "social organization of care" is defined by Glenn (2010, 5) as the structural and systemic ways in which care is allocated to those who need it, and the ways in which the responsibility to perform caring labour is distributed in a society. As Glenn notes, the ways in which care is organized in a society reflects the social values, beliefs, economic system, and political priorities of that society (6).

The social organization of care in Canada has been shaped by a long history of social narratives about who should provide care and how it should be provided. Historically, unpaid care work has been traditionally performed by women, usually the female relatives of the person requiring care, including wives, mothers, grandmothers, sisters, and daughters (Glenn 2010, 1). Caring labour has often been socially understood as something that comes naturally to women. Social narratives that ascribe the natural capacity and desire to perform care work to women remain influential today. Systemic racial oppression, prevailing racial stereotypes, and class dynamics have also played a role in constructing social narratives about who should perform care work. Historically, in Canada, as in other parts of the Global North, women of colour, immigrant women, and poor women have been pushed into domestic service, performing the most physically challenging and socially degraded forms of caring labour within the homes of wealthier individuals, typically those with racial privilege (Glenn 2010, 36). Historically and in the context of contemporary labour regimes, women of colour from the Global South are frequently compelled to leave their home countries as a result of extreme global wealth

inequality and are subject to immigration policies that systemically restrict them to low-waged and socially undervalued forms of caring labour.

My work explores this history, as well as contemporary challenges and debates, in order to better understand the current care crisis and the ways in which gender, race, and class dynamics shape the distribution of caring labour in Canada. I am especially interested in understanding two overlapping issues: (1) how assumptions about care serve to shape who provides care and how; and (2) how policies introduced to provide, govern, and support care in Canada have, in turn, serve to perpetuate and reinforce assumptions about care, and have shaped the work and lives of care providers. As noted above, a large body of scholarship has focused on elder care and child care, and an important cluster of research in Canada has focused on specific policies and clusters of care, such as the Live-in Caregiver Program and the related history of domestic care provision (see, for example, Arat-Koc 1997; Banerjee, Kelly, and Tungohan 2017). However, this work is generally siloed, and few studies explore care provision in these different sectors together. Indeed, what is frequently missing from existing work is an exploration of how other key policies and government interventions, such as Employment Insurance provisions for unpaid familial care, are part of a broader system of care provision, and how similar assumptions about care might underpin all these policy initiatives.

My work aims to fill this gap and is organised around these broad questions: what are the assumptions about care shaping the key policies and government initiatives that provide and support private, in-home care in Canada? Are there any common or similar assumptions about care underpinning different policies regarding in-home care? If so, what are these assumptions and how do these assumptions, in turn, shape the provision of care? I answer these questions by focusing on two important sets of federal policies that structure and support in-home care work

in Canada: federal Employment Insurance (EI) programs that allocate funding to unpaid, in-home family caregivers, and the Home Child Care Provider and Home Support Worker Pilot Programs, which regulate the immigration of temporary foreign workers employed as private in-home caregivers. As will be discussed below in more detail, I examined a wide range of policy documents, government websites and related policy materials to identify what, if any, similar assumptions were present. I used inductive coding to establish what these assumptions were and how they seemed to operate. A range of similar assumptions about care largely based on gender and began to emerge during my initial round of coding aimed at identifying patterns and common themes. Given this initial finding, I narrowed my focus and organised my research around answering these more specific questions: how do these sets of policies both reflect and reinforce a similar set of gendered assumptions and social narratives around care? What are the policy outcomes and consequences of these assumptions?

My work builds on existing scholarship on domestic care and the care crisis in Canada while filling important gaps in this work by showing that policies that shape the labour of unpaid family caregivers and paid immigrant care workers reflect similar and interrelated sets of gendered assumptions about care. Both groups of caregivers (who, as will be shown, are mostly women), are marginalized by policies that contribute to the systemic undervaluation of caring labour, particularly policies that reflect neoliberal approaches to care provision. Both unpaid family caregivers and paid immigrant care workers are treated by the Canadian state as temporary and invisible "solutions" to the care crisis. While a high number of paid home caregivers (both historically and in Canada's contemporary labour market) are from racialized backgrounds, and many are immigrants, my analysis found that gendered assumptions about care are most dominant and consistent in these policies. However, as will be further discussed in

chapter two, the impact of race and precarious immigration status do influence the outcome of the Home Child Care and Home Support Worker Pilot Programs, with real consequences for immigrant care workers. I suggest that the racialized profile of home caregivers is significantly tied to the history of these policies. For instance, as will be shown, some of the early domestic worker programs in Canada were dominated by agreements signed between Canada and Global South countries, such as the West Indies. Thus, while race is certainly a key issue in the history of policies regulating paid immigrant caregivers and I explore this history in detail, my analysis of the assumptions of care embedded across all these policy areas revealed more consistent gendered assumptions of care, as well as some class-based assumptions, than race-based assumptions. This thesis addresses these complex issues and findings in detail.

Theoretical Framework

This thesis is informed by feminist theoretical approaches, particularly feminist political economy, and feminist policy research on care. My methodology and methods, as well as my use of key concepts are informed by feminist work on labour markets and feminist political economy. The following are some key concepts relevant to the theoretical framework used in my work. In this thesis, I discuss "care work". The concept of care work is closely related to the term "reproductive labour", or the synonymous term "social reproduction", which are central to many feminist analyses of the gendered division of labour, particularly the analyses provided by Marxist and socialist feminists. Reproductive labour is defined as the physical and social labour required to maintain workers on a day-to-day and generational basis, including the maintenance of one's physical environment, fulfillment of physical and emotional needs, and the creation of relationships within a broader community (Bezanson 2006, 22; Fudge and Vosko 2001, 185; Glenn 1992, 1). Social reproduction includes the ways in which workers create and transmit

moral and social values, cultural norms and identities, survival skills, and knowledge (Bezanson 2006, 22). In Canada, like elsewhere, social reproduction is a form of labour overwhelmingly performed by women, which is often rendered invisible since it typically takes place outside of the formal paid labour market. Even though it often goes unrecognized as real work, social reproduction is necessary for the functioning of the paid labour market; it encompasses much of the "background" work required for workers to engage in paid labour (Glenn 1992, 2; Fraser 2014, 60). As Nancy Fraser argues in her 2014 article, *Behind Marx's Hidden Abode: For an Expanded Conception of Capitalism*, the labour of social reproduction makes wage labour possible by "help[ing] to produce new generations of workers and replenish[ing] existing ones, as well as [...] maintain[ing] social bonds and shared understandings" (61).

My methodology and theoretical framework draw heavily on feminist methods and theory. My theoretical approach is also intersectional in nature. By intersectional, I understand single-axis approaches to understanding care (i.e. those that analyze gender as separate from race and class and other axes of inequality) as incomplete. The gendered assumptions that structure the organization of care in Canada are closely intertwined with social narratives about race and class. I understand factors like race, class, and immigration status as "central factor[s]to shaping gendered experience" and proceed from an understanding that "women"' do not constitute a homogenous group of individuals with similar experiences of marginalization (May 2012, 156). As will be explained, the impact of race, immigration status, and class on caregivers has been important historically in Canada in terms of care and continues to shape who provides care and how.

Using a feminist, intersectional approach, I draw on and build upon three of Suzanne Day's (2013) care models as a framework to understand how different conceptualizations of care

are articulated through policy. Day's care models outline the different ways in which care is conceptualized and critiqued in caring professions and in care literature. While Day outlines four care models, I use the three most relevant to my analysis: the family model, the medical model, and the market model. The model that does not fit my research is the social model, which I have excluded because it focuses more on the interpersonal dynamics of micro-level caring relationships, rather than on the broader dynamics of care provision that are articulated through federal policy.

First, the family model adopts an understanding of care as an individual need to be accommodated and provided within the home. Within the family model, care provided within the context of family relations and located within the private sphere of the household is idealized. The unpaid labour of family caregivers is assumed to be a natural solution to the care crisis; family members are expected to "fill the gaps" left by welfare state retrenchment (Day 2013, 22). The family model relies on the labour of unpaid family caregivers assumed to be best suited to caring labour. Given the prevalence of status obligation and cultural narratives that distribute caring duties along gendered lines, these unpaid family caregivers are most often women (Glenn 2010, Braedley 2013).

The second model is the medical model, which defines care as the "management, monitoring, and treatment" of bodily ailments (Day 2013, 25). Like the family model, the medical model also conceptualizes care as an individual issue; health and illness are understood as the result of individual biological phenomena or choices, and social determinants of health are largely overlooked. The medical model prioritizes physical treatment of bodily ailments over the emotional labour inherent in care work. The prioritization of technical, physical care work over emotional care work is reflective of gendered hierarchies that diminish the importance of

feminized labour. However, some reactions against the prioritization of clinical and biological treatment have tended to privilege spiritual or emotional care work over daily forms of physical care work considered to be "menial" (Day 2013, 25-26). This reaction reflects the racial and class hierarchies described by Roberts (1997), whereby poor and racialized women are assigned "undesirable" physically strenuous and often messy tasks, while women with class and/or racial privilege perform less taxing forms of emotional support or supervisory tasks (55). As a result, the medical model minimizes the importance of both emotional care and the daily physical labour required to ensure the safety and comfort of care recipients.

The third model is the market model, which conceptualizes care as a quantifiable product to be bought and sold for a profit (Day, 2013, 26-27). Within the market model, care is understood as a service like any other, "performed on the basis of a market-based contract", with the goal of generating a profit (27). However, simultaneously, the market model relies on the notion that care is natural, unskilled, and altruistically performed to fulfill one's duty, allowing for the exploitation of low-paid care workers.

Day's care models provide a useful framework for analysing the ways in which care and care work are conceptualized and help reveal the limitations of policies that rely on the assumptions present within each model. Thus, my work is informed by her models to help identify and characterize the ways in which neoliberal policies reflect inequitable social hierarchies and assumptions about care work. In particular, I use Day's family model of care to highlight the inadequacies of current federal financial support for family caregivers, and use both the market model and the medical model to highlight the challenges experienced by immigrant care workers. Overall, Day's models help to show the ways in which policies regarding care reflect and reinforce pervasive assumptions about the nature of care and caregivers.

Research Approach and Methods

As noted above, I am interested in examining diverse sets of policies which govern and structure private, in-home care in Canada, in order to determine whether there are similar assumptions about care that inform these policies. I focus on two sets of policies to answer my research questions: (1) federal Employment Insurance (EI) programs that allocate funding to unpaid, in-home family caregivers, and (2) the Home Child Care Provider and Home Support Worker Pilot Programs, which regulate the immigration of temporary foreign workers employed as in-home caregivers. I selected these policies for two main reasons. First, the Home Child Care Provider and Home Support Worker Pilot Programs, and the polices that preceded them, are some of the core ways that the federal government has sought to fulfil the need for in-home child care and related supports for families. Similarly, the federal EI program is currently the primary way that the government supports and provides funding to in-home family caregivers. Second, despite the centrality of these two sets of policies for providing necessary care to individuals and families, scholars and policy makers do not examine these policies together. Instead, scholars tend to view these government interventions as separate and distinct sets of policies. In contrast to the dominant approach, my interest was to explore these policies together to see if policies regarding unpaid family caregivers and paid care workers share similar assumptions about the nature of care and caregivers.

Informed by diverse feminist scholarship, particularly feminist political economy and policy work, and feminist scholarship on care work and domestic care provision, I began with the assumption that policies are not crafted in isolation of society and social relations. As feminist policy scholars such as McPhail (2003) show, policies reflect value-laden beliefs and assumptions, even when they may appear technical or nonpartisan. In turn, public policy shapes

the lives of individuals and groups within society. Public policy directs and constrains the behaviour of individuals through the use of incentives and deterrents and the application of force. Further, public policy can also have an indirect effect on the collective consciousness of the people affected by them. Policies are shaped by, and also serve to reinforce and perpetuate commonly accepted social values and narratives. In turn, behaviours and actions of individuals within society can challenge or reinforce policies and the beliefs and assumptions behind those policies.

To identify if there are common assumptions and social narratives about care in these policies, and what these are, I use feminist critical discourse analysis and feminist policy analysis to uncover the assumptions that structure both the Home Child Care Provider and Home Support Worker Pilot programs for temporary foreign workers and federal Employment Insurance programs for unpaid family caregivers in Canada. I also use feminist policy analysis to analyze the gendered impact and outcome of the policies' implementation.

According to Halperin and Heath (2020), critical discourse analysis "seeks to expose connections between language, power, and ideology [...] It is principally concerned with the role of discourse in enacting, reproducing, and resisting social power abuse, dominance, and inequality" (368). Critical discourse analysis was developed as a critical response to the perceived tendency of discourse analysts — particularly those within the tradition of post-structuralism — to overlook the power structures that comprise reality by analyzing the social world as though it emerges and is maintained by discourse alone (367). Critical discourse analysis takes existing social structures seriously as constitutive of reality, and seeks to analyze the ways in which individuals, groups, and institutions with significant social power utilize discourse to reinforce and perpetuate their power. Public policies reflect existing social power

structures. At the same time, they have the capacity to create, reinforce, or change social power structures. Critical discourse analysis is a useful tool for investigating and drawing out the ways in which public policies implicitly bolster particular social power structures.

Specifically, I use feminist critical discourse analysis, which is focused on critically analyzing the role of discourse in maintaining (or disrupting) *gendered* social power structures (Lazar 2005, 1). As articulated by Lazar (2005), feminist critical discourse analysis centres gender as a core concept to show "the complex and subtle ways in which taken-for-granted social assumptions and hegemonic power relations are discursively produced, perpetuated, negotiated and challenged" (1-2).

According to Halperin and Heath (2020), critical discourse analysis requires the researcher to place discourses within their "historical and social contexts" (369), and then to establish that the discourse has "demonstrable effects" (371). I situate the current organization of care in Canada within the broader historical context of capitalism, especially the current era of neoliberal hegemony. A more thorough discussion of neoliberalism and its influence on policies related to care work can be found in the following literature review, but in short, "neoliberalism" refers to an approach to policy making that consists of the privatization of programs, services, and commodities based on the assumption that the state's role in the market should be as limited as possible, including in the provision of public goods. Neoliberalism also often involves the outsourcing and sub-contracting of services and work. Throughout Canada, the United States, and Western Europe, neoliberalism emerged in the early 1980s and has remained hegemonic since then, with significant consequences for care workers, as well as those who require care.

I adopt elements from the dialectical-relational approach in my feminist critical discourse analysis. Within the context of the dialectical-relational approach, social relations, institutions,

and power structures are not constructed and upheld *exclusively* as a result of language; rather, discourse is understood as an important part of the process by which people make meaning out of the social world (Catalano and Waugh 2020, 165; Fairclough 2003, 2, 10-11). Rather than providing a close linguistic analysis that focuses exclusively on the language used in the policies analyzed, I focus on the *social meaning* of the discourse contained within these policies. As stated by Fairclough (2003), discourse is "an irreducible part of social life, dialectically interconnected with other elements of social life" (2). As such, my aim is to study the meaning and impact of the discourse communicated by the Canadian state through its policies in a broader social context.

Using feminist critical discourse analysis, I started by examining the two policy clusters separately in order to first identify themes and patterns in each cluster. I used a combination of both inductive and deductive coding. I started with the federal EI programs and used an open coding (inductive) process. I closely read the policy and then looked at relevant texts about family caregiving published by the Canadian federal government, including the financial advice offered to caregivers alongside information about EI benefits, the 2016 publication "Balancing Work and Caregiving Duties: Tips for Employed Caregivers of Family or Friends" from the Federal, Provincial and Territorial (FPT) Ministers Responsible for Seniors Forum, and some information regarding the federal tax credit available for caregivers. I generated a list of themes and dominant issues regarding care that emerged from this policy. I then turned to the second policy cluster and engaged in a similar inductive coding process.

Similarly to my coding process for EI programs, I started with open (inductive) coding to categorize excerpts from various documents and websites in order to establish if there were any themes and patterns. I started by closely reading the Home Child Care Provider and Home

Support Worker Pilot Programs materials on federal government websites. My first step was open (inductive) coding to categorize excerpts from these diverse documents and websites in order to establish if there were any themes and patterns. I focused on the programs' descriptions from the Ministry of Immigration, Refugees and Citizenship Canada's (IRCC's) website and the admissibility criteria used by IRCC staff to assess applications to the programs. I also used government press releases and comments made by Members of Parliament (accessed through the Hansard Index) regarding the immigration of care workers to Canada to provide contextual information. Due to the fragmented nature of the pilot programs' descriptions, I also referred to articles, guides, and quotes from immigration consultants and lawyers to understand the challenges faced by prospective immigrant caregivers in applying for these pilot programs. Similarly to the process followed with policies regarding EI benefits, I used inductive coding to generate a list of themes and patterns regarding care in these domestic care policies.

My initial round of inductive coding resulted in a longer list of initial themes, some of which were similar or repetitive. Through this initial coding process and preliminary assessment of my data, an answer to my overall question - are there common assumptions regarding care underpinning key policies and government initiatives that provide and support private, in-home care in Canada – began to emerge. I began noting that there were common assumptions – mostly gendered assumptions – despite the seemingly vast differences in the way supports are provided in each policy. Thus, I then began to narrow the codes into the most dominant themes that stretched across all the policies. I did so to identify more clearly what these gendered assumptions were, and how these assumptions, in turn, shape the provision of care. Four core themes emerged. First, care is portrayed as temporary in nature. Second, care work is depicted as secondary in importance and legitimacy to other forms of work. Third, care is poorly

compensated. Fourth, care is conceptualized as a private matter, rather than a public concern. Informed by secondary research on these topics and my inductive coding process, I then engaged in a process of deductive coding by using these themes to more clearly understand how these assumptions about care shape the policies, and in turn, shape the provision of care.

Similarly to the ways in which feminist methods inform my discourse analysis, I also draw on feminist policy analysis to better understand the policies, their development, and implementation, with reference to assumptions about care. Feminist policy analysis offers a valuable framework to help me understand the gendered impacts of the Home Child Care Provider and Home Support Worker Pilot programs and Employment Insurance benefits for unpaid family caregivers. According to Kanenberg (2013), feminist policy analysis involves examining the gendered origins of policies and analyzing the ways in which states use policy (including policies that are typically understood to be gender-neutral) to regulate gender by constructing and restricting the opportunities available to women (134). Feminist policy analysis offers a value-driven alternative to gender-blind models of analysis. Although my work does not directly address all questions included in McPhail's (2003) feminist policy analysis framework, some of the questions raised in this research project are similar to the questions included in her framework; for example: "Are women's unpaid labour and work of caring considered and valued or taken for granted?" (55); and "Where are the policy silences? [...] What policy is *not* being proposed, discussed, and implemented?" (58).

As will be shown in the chapters that follow, my research shows how two sets of policies that may appear dissimilar are built upon a similar set of gendered narratives about care provision.

Chapter Breakdown

The remainder of this chapter situates my research in broader scholarly debates and developments. The literature review section below focuses on four main clusters. First, I discuss scholarship that offers a historical analysis of care provision in the Global North, in order to highlight the ways in which the distribution of care work has been shaped by various assumptions about gender, race, and class throughout history. Next, I focus on scholarship that discusses caregiving within the context of neoliberalism, in order to illustrate how neoliberal policy has impacted the provision of both paid and unpaid care, and to highlight the impact of both privatization and the international flow of care workers. Third, I discuss scholarship related to child care provision in Canada, to highlight both the ongoing labour challenges within the field and the ways in which they remain under-studied within the current literature, as well as to provide context for my own research. Fourth, I discuss scholarship focused on elder care in Canada. Similar to my discussion of child care, I discuss the prevalence of labour issues within the field and highlight gaps within the literature, noting that the field is dominated by work focused on long term residential care facilities rather than in-home caregiving.

My two substantive chapters explore the policies and present my findings. Chapter one analyzes policies related to the allocation of federal funding to unpaid family caregivers: the Employment Insurance Compassionate Care Benefit, the Employment Insurance Family Caregiver Benefit for Children, and the Employment Insurance Family Caregiver Benefit for Adults. The Canada Caregiver Credit is briefly referenced in this chapter, but tax credits are not the primary topic of analysis, largely due to the scarcity of rich texts offering possibilities for fruitful critical discourse and policy analysis. My analysis focuses on the federal government's eligibility criteria for caregivers, definitions of compensable caregiving, and rates of

compensation (“Benefits for Caregivers” 2022). The Canadian federal government’s definitions of care work and its eligibility for financial compensation represent a form of discourse utilized by a power-wielding institution.

Chapter two turns to analyze policies related to the immigration of temporary foreign workers into Canada to be employed as private in-home care workers: namely, the Home Child Care Provider and Home Support Worker Pilot Programs. Similar to the structure of chapter one, this chapter provides an overview of the policies followed by an analysis of the assumptions I found within these texts. To situate my work within broader debates, highlight the research on which I draw, and note gaps within the current field of scholarly research, the remainder of this section provides an overview of core scholarly works and debates.

Literature Review

There are four broad and often overlapping areas of scholarship that lay the groundwork for my study. The first area consists of historical analysis of the provision of care in North America and Western Europe throughout history (specifically that which focuses on the gender, class, and racial hierarchies that have impacted the distribution of care work at different points in history). The second area of scholarship focuses on the state of caregiving in an environment of neoliberal hegemony. Literature in the first cluster identified above — historical analysis — helps to reveal how we came to arrive at the current inequities that mark the organization of care in Canada today, while literature in the second cluster provides insight into the impact of privatization and globalization on the distribution of care work. Neoliberal policies have significantly impacted the provision of care in Canada through the processes of welfare state retrenchment and the international movement of care workers from the Global South to the Global North. The third and fourth clusters of literature consist of work focused on particular

forms of care work and their associated industries. The third cluster consists of research on child care in Canada. There is a wide range of literature about child care in Canada, but much of this work examines issues that are beyond the scope of this thesis, such as the gaps in child care services and the need for affordable child care. I provide a brief overview of some of the key points raised in this work largely to identify the need for child care reform and scholarly agreement on the need for affordable and accessible child care. Thus, I focus mostly on research on the labour dynamics of child care provision. Finally, the fourth cluster consists of research on elder care, including research on home care and long-term residential care.

Brief History of Care Work Under Capitalism

The current organization of care work cannot be understood independently of the historical processes that created, shaped, and sustained it. Silvia Federici's (2004) work is especially instructive in understanding this history, specifically regarding the devaluation of reproductive labour throughout the period of transition from feudalism to capitalism. As she shows, prior to the advent of capitalism, work was "organized on a subsistence basis"; labour on a feudal farm was divided by gender to a much less significant extent than it was under the capitalist mode of production (25). Women's labour was not devalued in the same way that it was under capitalism, as it did not occur in the context of significantly different social relations from the labour performed by men. The existing sexual division of labour that casts social reproduction as women's work is not universal; it is the historical product of capitalism (Fraser 2014, 62). As social and economic life became further monetized and commercialized under capitalism, the perceived gap between reproductive and productive labour grew. As argued by Braedley (2013), the perceived division of public and private spheres is an important element within the establishment of hierarchies of labour within capitalism, in which women's natural

place is thought to be within the home, performing reproductive labour, while men are associated with the "productive" labour and political activity of the public sphere (61-61). Throughout the 17th century in Western Europe, a new sexual division of labour emerged that defined women as "non-workers" (Federici 2004, 92). In many cases, even when women *did* perform paid work outside of their homes, it was legally and socially defined as "housekeeping" (94). Through a dynamic that Federici calls the "patriarchy of the wage", women were often legally excluded from the wage in a variety of different ways (2004, 97-98). The patriarchy of the wage operated by not only rendering reproductive labour as invisible, but also through legal measures that denied women wages for paid work outside the home. In England, in the late 16th and throughout the 17th century, married women's earnings were legally the property of their husbands; thus, according to many parish records from the period, payments for women's labour were often made directly to their husbands (98). Through the patriarchy of the wage, women became constructed as non-workers (regardless of their lived realities), and much of their work both within and outside of the home was concealed.

Women's work within the home — now defined as non-work — became perceived as "a natural resource, available to us all, no less than the air we breathe or the water we drink" (Federici 2004, 97). Dominant social narratives that mark care as natural to women are not value neutral. As Susan Braedley (2013) contends, the social organization of care is an arrangement built on power relations ingrained in scientific and economic discourses, as well as within cultural scripts. Because of these power relations, care is not feminized in a neutral way; we do not value the caring labour of women as equal to the labour market activity of men. Rather, the naturalization of care as something which comes instinctually to women perpetuates understandings of care as unskilled and of low value (Braedley 2013, 60). Here, it is evident that

current discourses that define care as natural and unskilled have their roots within the earliest stages of capitalism.

Glenn (2010) argues that the widespread belief that women are the most appropriate and natural caregivers arises because of status obligations, which she defines as integral to "public and private *morals* that are internalized by members of a community and enforced by others in the community" (88, emphasis in original). Status obligations shape our shared social understandings of what it means to be a good mother, a good wife, a good daughter, a good sister: a *good woman*. In their upbringing, many girls are taught (whether intentionally or not) that performing caring labour for others, especially for one's family, is an integral part of good womanhood. As a result of this gendered socialization, many girls are raised to accept that they must provide unpaid or low-waged care work in order to gain value and worth as women (Braedley 2013, 60).

"Good" femininity became increasingly characterized as holding particular spiritual and moral qualities. Schecter (1998) and Roberts (1997) describe the ideological valorization of an essential "feminine" spirituality respectively as the "cult of true womanhood" (26) and the "cult of domesticity" (55). Within the cult of true womanhood/domesticity, women's role as "guardians" of the home — understood as a refuge from the stress of external, public life — was idealized (Schecter 1998, 26).

Federici (2004) hints at the emergence of the cult of true womanhood/domesticity in her claim that, at the end of the 17th century, dominant cultural narratives about women's inherent qualities shifted. During the peak of the witch hunts that took place across Europe throughout the 16th and 17th centuries, religious and cultural messaging characterized women as wild, disorderly, even "demonic" beings (Federici 2004, 102). Women were portrayed as unruly,

sexually aggressive, driven by lust, and naturally disobedient. As the witch hunts came to an end, having destroyed women's autonomy over their labour and their bodies, a new dominant narrative about women emerged. This social ideal of womanhood (defined by the roles of wife and mother) projected an image of women as chaste, quiet, obedient, hardworking, submissive, and spiritually pure. Schecter (1998) situates the emergence of the cult of true womanhood/domesticity in Canada within the mid-nineteenth century, at which point industrialization was underway, the wage relation had become the dominant mode of organizing labour, and a middle class began to emerge (26). The concept of the cult of true womanhood/domesticity was constructed around the valorization of a particular form of white, Christian womanhood. As will be discussed further, in Canada, this construction was incorporated into colonial narratives. Within the cult of true womanhood/domesticity, women were constructed as possessing a unique feminine ability to impart and preserve moral purity (Federici 2004, 103). Despite the economically degraded nature of women's work, women who fit into the role of the ideal domestic wife and mother were perceived as spiritually and morally pure.

However, Roberts (1997) points out, reproductive and caring labour involve a significant amount of labour that is neither spiritual nor passive, encompassing "nasty, tedious, physical tasks" (55). Much of the labour required to meet rising standards of household hygiene and neatness fell well outside the realm of the light, spiritually uplifting labour considered suitable for women. There is nothing dainty or passive about scrubbing floors and toilets, doing laundry, carrying wood or coal for a stove, or addressing the various bodily fluids produced by infants, ill family members, or the elderly. Indeed, a significant amount of reproductive labour consisted of strenuous physical labour, especially prior to the invention and widespread adoption of various

labour-saving household technologies, such as mechanized washing machines, which eased the physical burden of housework. The reality of reproductive labour, therefore, departed significantly from the vision of the ideal woman as a pure spiritual and moral guide, elevated above dirty and often unhealthy physical work.

According to Glenn (2010), to resolve this contradiction between the ideological construction of good femininity and the "dirty" physical reality of women's work, care work was separated into two separate categories: repetitive, strenuous, and messy physical caring labour was denigrated as menial and was separated from "supervisory" and "spiritual" care work (36). With the separation of caring tasks into two categories, social narratives about *who* was best suited to perform each type of care work intensified. Women with racial and class privilege (most often upper- and middle-class white women) were able to devote their time to forms of more socially valued caring labour, including volunteering for socially acceptable charities, participating in parent and neighbourhood councils, and entertaining guests in their homes. Women who lacked racial and class privilege, particularly working-class women of colour and immigrant women, were deemed best fit for the most physically taxing and least socially valued forms of care work, such as scrubbing toilets and changing diapers. This is not to say that women of colour did not also perform significant emotional labour in their work as carers, but these women were socially constructed as unskilled workers best suited to menial and undervalued labour that privileged women wished to avoid. Women's caring labour, which had been originally devalued because of the separation of the private and public spheres, became once again separated, this time in order to devalue the labour of less privileged women.

Thus, housework underwent a "cleansing" process; in which its "undesirable tasks" were split off and assigned to less privileged women, while privileged women maintained their status

as moral and spiritual guardians of the household (Roberts 1997, 55). In order to preserve this separation of housework, a servant class of women was constructed. These women, who were structurally subordinated because of their race and/or class, were coerced into serving middle- and upper-class families, most of whom were white (Roberts 1997, 56). In Canada, "undesirable" domestic tasks were also assigned to individuals who were structurally disadvantaged due to their gender, race, class, and immigration status. For example, within Canada's culturally genocidal residential school system, which operated from 1831-1996, Indigenous students were forced to perform unwaged and often extremely physically strenuous manual labour. Indigenous boys were typically expected to perform agricultural labour, while Indigenous girls received "domestic training" and performed household labour and service tasks, which residential school administrators saw as appropriately "in line with their future roles as […] domestic workers" (Giancarlo 2020, 464). Indigenous children were therefore forced "into the settler colonial world, but at the lowest level: in serving roles supposedly appropriate for their station in the new capitalist society" (467).

Poor and working-class immigrants were also coerced into performing gruelling and low-waged or unwaged domestic labour in the households of more privileged Canadians. One striking example of this is the case of the British Home Children. Between 1863 and 1939, over 100,000 poor British children (many of whom had been living in poorhouses) were brought to Canada by child emigration organizations (Johnson 2021, 2). Most of these poor children were sent to perform hard agricultural or domestic labour for Canadian families, essentially working as indentured servants. Many British Home Children reported unsafe working conditions, abuse, neglect, and denial of wages. Leaders of child emigration organizations and Canadian families who employed the British Home Children often justified the poor working conditions and

extremely strenuous forms of labour assigned to these children by portraying the child emigration program as "the salvation of orphaned British children to loving Canadian families" (2). In many cases, however, children sent to Canada had living parents and families in England, who often reported that they had not consented, or even been informed, of their child's emigration to Canada.

Some Canadians objected to the British Home Children, not because of the program's unethical nature, but because they believed these impoverished children had "inherited tendencies to evil" or were "tainted and corrupt with moral slime" as a result of their poverty (4). Class-based discrimination against the British Home Children was sometimes conflated with racist sentiments; in the famous Canadian novel *Anne of Green Gables*, the character Marilla Cuthbert expresses discomfort at the idea of adopting a British Home Child, describing them as "street Arabs" (5). In Canada, as in the United States and other parts of the Global North, throughout the 19th and early to mid-20th century, housework was not only considered to be women's work, but was also distributed based on class and race. Women of privileged classes and races were often able to slough off the most physically taxing and least socially valued forms of domestic labour. Women and girls who were structurally disadvantaged because of class and/or race hierarchies were subjugated to the most strenuous and socially degraded forms of care work to a much greater extent than was the case for women with class and racial privilege.

The concealment and appropriation of the labour of women and people of colour have been consistent elements of capitalism throughout its different historical iterations, from the earliest periods of primitive accumulation described in Federici's work, through the brutal era of Dickensian industrial capitalism, through the age of Keynesian welfare capitalism, to the neoliberalism of today. According to Fraser (2014) the appropriation of women's unpaid

"homemaking" labour was central to the Fordist system of mass production and consumption in developed countries during the post-war period. During the Fordist period, and still today, capitalist accumulation relies on the perpetuation of particular background conditions that occur outside the realm of wage labour (59). The establishment and continuation of the capitalist mode of production and accumulation requires social reproduction to occur in the background, as unpaid and separated from the world of waged labour, obscured, and made invisible within the "private" sphere of the home. Within capitalism, where capital is valued over all else, the unpaid nature of social reproduction serves to create and enforce relationships in which those who earn wages are structurally dominant over those who perform reproductive labour, despite the critical importance of caring labour for the ongoing functioning of the capitalist system (Fraser 2014, 62). Gender, along with race, both represent "hidden abodes" of capitalism, by which the labour of women and racialized people has been historically and contemporarily understood as existing outside the "free" labour contract of the white, male, proletarian (Fraser 2014; Dawson 2016; Fraser 2016).

During the peak of Keynesian welfare capitalism, generally understood as beginning after the end of World War II and ending in the 1970s, some forms of care work "were transformed into public services and public goods" as part of a broader process of social policy reform (Fraser 2014, 62). However, as argued by many feminist political economists, the policies that shaped the contours of the welfare system during the global age of Keynesian welfare capitalism continued to be based on the model of the male breadwinner, even during the golden age of Keynesian welfare capitalism. In Canada, benefits originating in the era of Keynesian welfare capitalism were distributed based on the standard employment relationship, defined by full-time, long-term status, and directly supervised employment by a singular employer (Vosko and Clark

2009, 27). As will be shown in chapter one, this structure of benefit administration is still influential today. In Canada, as elsewhere in the Global North, the standard employment relationship reflects a form of employment that was historically only available to male workers (Vosko and Clark 2009; Lewchuk et al. 2008). Throughout the period in which Keynesianism was the dominant economic model in Canada, public goods were frequently allocated based on one's employment status, or one's "dependence" on a worker engaged in the standard employment relationship. The reproductive labour of women was often unrecognized, and women were defined "primarily as dependents whose benefits were pegged to their husbands' status as wage-earners" (Struthers 2013, 164).

In sum, as these scholars show, care work has been systemically undervalued throughout all iterations of capitalism. Nonetheless, given the global hegemony of neoliberalism and its dominant role in shaping the policy context of today, this current era requires particular attention. It is to the impact of neoliberalism on care provision that I turn in the following section.

Neoliberalism and Care: Privatization and Global Chains of Care

The second important cluster of scholarship that informs my work is research on the impact of neoliberalism on care provision. Scholarship on neoliberalism is vast and varied, with some scholars using the term to signify a broad set of ideas, and others using it to describe specific policies. As Dean (2014) writes, neoliberalism has been used to "characterize everything from a particular brand of free-market political philosophy and a wide variety of innovations in public management to patterns and processes found in and across diverse political spaces and territories around the globe" (150). Many political economists use the term to refer to a political ideology or orientation that came to prominence in the early 1980s, which embraced market-based policies and economic institutions, as well as a willingness of governments to use the

market to discipline the population (Struthers 2013). My research is informed by this scholarship, particularly the work of feminist political economists (Armstrong 2013; Fudge and Vosko 2001). Following their work and other scholars, I understand that the core of neoliberalism can be seen in policies of deregulation, privatization, lower taxes, smaller states, free trade and free markets. These policies have been implemented around the world, starting first in Chile under Pinochet and the United Kingdom and United States under Thatcher and Reagan respectively. In Canada, the emergence of neoliberalism is generally associated with the election of Brian Mulroney's Progressive Conservative government in 1984 (Struthers 2013, 165). Many Global South countries were forced to adopt neoliberal policies through structural adjustment policies imposed by the International Monetary Fund (IMF) and World Bank.

As a result of neoliberal policies, many forms of reproductive labour have been transferred out of the welfare state, primarily back to women providing unpaid labour in families, but also to the private sector (160). As will be further explained below, in the context of neoliberalism and related welfare state retrenchment, social narratives and public policies' construction of care as a private responsibility rather than a public resource have intensified, with profound consequences for both unpaid family caregivers and paid care workers. Neoliberal policies have impacted care provision significantly, leading to privatization, union busting, outsourcing and sub-contracting of labour within the care sector (Armstrong 2013, 189). Further, the neoliberal era has been marked by cuts to public spending on health care, child care, and elder care, often resulting in poorer working conditions and lower wages for paid care workers. Neoliberalism has also impacted the distribution of financial support to family caregivers, as neoliberal governments typically cut social welfare payments and favour "workfare" policies which push welfare recipients to return to the paid labour market as soon as possible (189).

As many scholars, such as Pat Armstrong (2013), have noted, neoliberal economic reforms have led to significant changes in healthcare, child care, and other policy areas. In particular, neoliberal policies have resulted in the retrenchment of the welfare state and the privatization of many forms of care. In particular, scholars have also drawn attention to the impact of neoliberalism on the transfer of caring responsibilities to migrant care workers, most of whom are women (Ehrenreich and Hochschild 2002). The pressures of global capitalism and neoliberal market policies often create conditions that push women from the Global South to seek employment in the Global North, where they are often relegated to low waged care work. Neoliberal policies have resulted in the ongoing privatization of many forms of care, which, as will be shown, have been offloaded onto women, both as unpaid family caregivers and as low waged migrant care workers.

According to Daly (2013), any meaningful reimagining of care requires us to challenge the dominant "market ethos" of neoliberalism, which defines care as a transaction and holds independence as the utmost virtue (35). Within the hegemonic neoliberal system of governance, the state has consistently mobilized discourse claiming that it is necessary to cut back on costs of publicly funded care, often resulting in inadequate patchwork systems of care provided by family members, low-waged home care workers, or health institutional care workers. As neoliberal policies of privatization have developed and intensified, services formerly considered to be public goods provided by the welfare state have been frequently transferred to women acting as unpaid caregivers within their families (Struthers 2013, 160). Unpaid family caregivers (most of whom are women) have received very little financial support from the state within the residual welfare state shaped by neoliberal ideology and policy. Instead, unpaid family caregivers have been primarily understood as a "policy solution" by perpetuating discourses of care as a family

responsibility, thus allowing neoliberal governments to offload care from publicly funded options, consistent with the neoliberal tendency towards welfare state retrenchment and austerity (Struthers 2013, 167).

Alongside unpaid family caregivers, paid migrant care workers are another pool of care workers treated as a policy solution for neoliberal governments seeking to offload caring responsibilities from the public sector. According to Ehrenreich and Hochschild (2002), the international flow of migrant women caregivers can be largely attributed to the pressures of global capitalism. On the surface the international flow of care workers may appear as a matter of individual choice. However, Hochschild (2002) explains that the "yawning gap between rich and poor countries is itself a form of coercion, pushing Third World mothers to seek work in the First for lack of options close to home" (27). For decades, beginning in the 1980s, many states in the Global South (often formerly colonized) facing balance of payments crises have been forced to turn to the International Monetary Fund or World Bank for loans. These loans often carry several conditions — frequently encompassed within Structural Adjustment Programs — that enforce austerity policies and massive cuts to healthcare and social services (Ehrenreich and Hochschild 2002, 8). These policies often disproportionately affect women, who make up a significant proportion of workers in the health and social service sectors. Austerity policies often result in cutbacks within the public sector, resulting in loss of employment for workers. Austerity policies also often result in cutbacks to welfare programs and social support services relied upon by families. In many cases, workers face limited options and low wages within their home countries, pushing them to seek employment overseas.

Across the Global North, the elderly are living longer than ever before. Throughout the 20th century, particularly in its latter half, women entered the labour force en-masse, and their

male counterparts have not taken on significant additional caring tasks to bear the load of reproductive labour more equally (Ehrenreich and Hochschild 2002, 9). As a result, the number of people requiring care has increased, while the number of people willing and able to provide care has decreased (Glenn 2010, 1). This "care deficit" in developed nations works as a "pull" factor for migrant women seeking employment. Thus, migration often works as a "private solution to a public problem" (Hochschild 2002, 18). As explained by Hanley, Larios, and Koo (2017), countries in the Global North (which hold disproportionate voting power within the IMF and World Bank) treat the migration of a "temporary, exploitable workforce" of caregivers as a cheap way to cover the care work that cannot be offloaded to unpaid family caregivers, without requiring any significant investment into public resources and infrastructure (131).

Attempts to solve the care crisis by coercing women of colour into care work in the Global North have far-reaching consequences. According to Parreñas (2002), in the Philippines, where care is the "primary export", migrant mothers are often forced to leave their own children in the care of a family member or friend while they travel across the world to provide care for more privileged children and families (41). Even though many migrant mothers attempt to maintain close relationships with their children through frequent correspondence, children of migrant care workers often experience significant emotional loss when a parent emigrates overseas in search of work (Parreñas 2002, 42). The mass transfer of caring labour from the Global South to the Global North does not resolve the care crisis; rather, it simply displaces it (Parreñas 2002, 41).

Parreñas (2002) also points out that within discourse produced and disseminated by the Philippines' government and media in the early 2000s, migrant women were often constructed as villains, blamed for the separation of families and the suffering of children, despite the economic

significance of their remittances (40). Glenn (2010) notes a similar pattern within the United States; the coercive labour regimes that push women of colour into poorly paid domestic labour detract from these women's ability to care for their own families (37). Glenn (2010) claims that: "[t]o add insult to injury, because they could not live up to the ideal of full-time motherhood, poor women of color were seen as deficient mothers and caregivers" (37). Rather than attributing the socio-economic challenges faced by communities of colour to generations of enslavement and exploitation, a discriminatory labour market, or a woefully deficient welfare state, women of colour were demonized as dependent and parasitic welfare queens: the source of all problems within their families and communities (Glenn 2010, 100).

This scholarship makes it clear that neoliberal policies have further devalued the labour of care workers. In the neoliberal era, unpaid caregivers have been expected to shoulder the burden of care that is no longer considered a public good due to welfare state retrenchment. At the same time, paid care work has been increasingly marginalized. Paid care workers — many of whom are immigrant women — have been subject to labour precarity, unsafe working environments, and low pay. Neoliberal policies fail to adequately value both recipients and providers of care, resulting in the proliferation of policies that define care as either a private responsibility or a profit-seeking venture. These key insights regarding neoliberalism inform my work, which focuses on two sets of policies that reflect neoliberal values and perspectives on care, resulting in the marginalization of care workers and the devaluing of care work.

Child Care in Canada

A significant amount of scholarship on care in Canada that focuses on child care in Canada centres on the need for affordable child care, and on the impact of various child care practice on children's health and well-being. For instance, some scholars work primarily within

the field of paediatric health, researching optimal child care practices and their impact on children's health (Armstrong 2021; Keon 2009). When it comes to research regarding public policy, one of the issues most often studied by scholars working in this field is the need for affordable child care. This scholarship demonstrates that child care affordability is indeed a major issue in Canada, makes a case for affordable child care, and also demonstrates the education benefits of such care. For instance, a 2016 report from the OECD showed that Canadian families with two incomes spend an average of 15% of their income on child care, making Canada the 6th most expensive for child care out of 35 analyzed countries (Evans 2016, para. 3). Child care is even less affordable for families with one income, who spent an average of 32% of their income on child care. For single income families seeking child care, Canada ranked as the 3rd most expensive (para. 5). The Canadian federal government states that it is working with provincial and territorial governments to support child care affordability, and it aims to bring child care fees across Canada down to $10/day by 2026, but at the time of writing, child care across Canada remains expensive ("Toward $10-a-Day: Early Learning and Child Care", 2023). In Canada, a significant amount of research on child care has focused specifically on Quebec, due to its universal affordable child care system[1]. Quebec's affordable child care policy was first implemented in 1997, offering licensed centre or family-based child care for $5/day, later increasing first to $7/day, then to $8.50/day (Kohen et al. 2008). Some scholars have focused on the impact of Quebec's affordable child care policy on parents (particularly mothers) and children in the province. In particular, scholars have noted the impact of affordable child care on labour market participation for mothers. The introduction of universal child care in

[1] Child care policies vary between provinces. In B.C., the provincial government offers eligible families an Affordable Child Care Benefit, which was expanded in September 2023 to partially subsidize child care for preschool and school aged children ("Affordable Child Care Benefit" 2023).

Quebec significantly increased maternal labour market participation for mothers with children between the ages of 1 and 4 (Haeck et al. 2015, 146). In the years immediately following the implementation of Quebec's universal child care policy, almost 70,000 mothers entered the paid labour force (Cleveland et al. 2021). Some scholars, such as Albanese (2007) have also studied the impact of affordable child care on children's development and behaviour, arguing access to universal child care has allowed children to develop social skills that they may not have otherwise developed without access to early childhood education programs (132).

Above, I have provided a brief outline of some of the arguments used by scholars advocating for the implementation and expansion of affordable child care policies across Canada. Child care affordability is indeed a significant issue, and many researchers focused on this issue provide compelling arguments in favour of universal affordable child care. However, much less attention is centred on workers' rights and labour issues with regard to child care. Indeed, there is a gap on scholarship on child care in Canada when it comes to thorough research into the labour dynamics of the sector. Though there is a gap in academic research focusing on child care labour in Canada, journalistic news reports reveal several significant labour issues within the sector that have remain under-studied within academic scholarship.

In Quebec, child care workers have expressed dissatisfaction with working conditions, wages, and the social value awarded to their work. In a study of child care providers and parents receiving child care services in rural Quebec. Albanese (2007) states that many child care providers reported feeling undervalued, unappreciated, and exploited, explaining that many people did not understand the significant physical and emotional labour they performed every day, often for very long hours with no breaks (133). Quebec's child care workers have engaged in labour action a number of times in recent years due to low wages. In 2020, the union

representing home child care workers went on strike, demanding wage increases. In a vote held on March 8th to commemorate International Women's Day (with women making up 99% of the union's membership), 97.5% of members voted for a general walkout. The strike vote took place after negotiations broke down with Quebec's Minister of Families, who offered to raise wages for home child care providers by 6 cents, for an hourly wage of $12.48. Members of the union understandably condemned this offer as an "insult", demanding a 30% wage increase, bringing their hourly wage up to $16.75 ("Quebec's home child care workers to go on unlimited strike" 2020). In September 2021, public child care workers employed in CPEs voted in favour of strike action, after their collective agreement had been lapsed for 18 months due to the Quebec government's insufficient offers regarding wage increases ("Public daycare workers across Quebec to strike for 1 day next week" 2021).

Labour issues within the Early Childhood Education and Care (ECEC) sector are not limited to Quebec. Across Canada, early childhood educators and day care providers (over 96% of whom are women) are notoriously underpaid, earning significantly lower salaries than the median for all workers in Canada, as well as less than the median wage for female workers in Canada, despite the majority of ECEC workers possessing post-secondary credentials (Child Care Human Resources Sector Council 2009, 5). Smith (2022) argues that social beliefs that portray care as an unskilled and natural feminine attribute have contributed to societal perceptions of child care as a "service" rather than a "profession" (356). She describes child care workers as "prisoners of love", whose emotional relationships with the children they care for are exploited to discourage labour action and maintain low wages (356). During the COVID-19 pandemic, labour issues within the ECEC sector intensified. Smith (2019) reports that many of the ECEC professionals she interviewed highlighted the challenges of operating child care

centres safely while receiving conflicting and ambiguous instructions from regional health authorities, provincial Ministries of Health and Ministries of Children, the federal Ministry of Health, and child care licensing organizations (359). ECEC workers were often not provided with clear guidelines indicating whether their centres should be open or closed, the number of children permitted to attend, and how to handle exposure to COVID-19 amongst staff and children. ECEC workers also reported feeling "unprotected", working without access to adequate cleaning supplies and clear protocols, in close contact with unmasked children, often while being discouraged from wearing masks themselves to avoid frightening the children in their care (360). Many of the ECEC workers interviewed by Smith (2022) also reported extremely high levels of anxiety and stress about contracting COVID-19 themselves or being incapable of guaranteeing the health and safety of the children in their care. From Smith's interviews, it is clear that the COVID-19 pandemic took a serious toll on the mental health of many early childhood educators, with interviewees reporting various symptoms such as "burst[ing] into tears for no reason", being unable to sleep at night, and withdrawing emotionally from colleagues and children (2022, 361). While working in high risk, emotionally and physically draining circumstances, described by some as traumatic, many ECEC workers reported feeling unappreciated and unrecognized as essential workers throughout the COVID-19 pandemic.

From this brief survey of some important scholarship and emerging research on early childhood education and care in Canada, it is clear that Canada still has far to go in addressing labour issues within the child care industry. ECEC workers are subject to low wages, unsafe working conditions, and a lack of social recognition and respect for their labour. The inequities faced by paid child care workers in Canada reflect gendered assumptions about care. The skills required to provide early childhood education and care are often unrecognized and unrewarded,

due to the assumption that women (who make up an overwhelming majority of the sector) are natural caregivers. Currently, the field of scholarship on child care in Canada focuses primarily on issues of child care affordability, and on assessing the impact of child care programs and practices on children's well-being. These issues are undoubtably important and have a significant impact on the lives of Canadian children and families. However, scholarship regarding the field's labour issues remains limited, though some has emerged in response to the unique challenges of the COVID-19 pandemic. Further, literature regarding child care in Canada tends to be siloed, examining paid ECEC services in isolation from other forms of care, including unpaid care. My work helps to fill these gaps by highlighting labour issues within care provision sectors, and by viewing care holistically to assess whether policies addressing different forms of care work are linked by a similar set of underlying assumptions.

Elder Care in Canada

The provision of care in long term residential care facilities is a central focus in research on elder care in Canada. The proportion of public funding and ownership of long-term residential care facilities vary significantly from province to province. In Canada, there are 2,076 long term residential care facilities, 46% of which are publicly owned. Of the 54% of long term residential care facilities that are privately owned, 29% are owned by for-profit organizations, and 23% are owned by non-profit organizations (Canadian Institute for Health Information 2021). Each province has a different proportion of publicly and privately funded care. In the Northwest Territories, Yukon, and Nunavut, 100% of long term residential care facilities are publicly owned. In contrast, 100% of New Brunswick's long term residential care facilities are privately owned. In British Columbia, of the total 308 long term residential care facilities in the province, 35% are publicly owned. 65% of the province's long term residential care facilities are privately

owned: 37% are owned by private for-profit organizations, and 28% are owned by nonprofit organizations (CIHI 2021). The privatization of long term residential care for seniors is a key issue discussed within a significant amount of the literature. Privatization of long term residential care threatens the well-being of both residents and workers, especially when facilities are owned by large for-profit corporations (Armstrong et al. 2015). Privately owned long term residential care facilities are often financially inaccessible to many seniors without significant wealth, and are able to raise fees for residents' care significantly and without warning, resulting in sudden evictions (often involving the abandonment of an elderly resident in an emergency room) that fail to respect the health and dignity of residents who are unable to keep up with fee hikes. Owners of private long term residential care facilities are also able to pick and choose which residents to accept. As a result, owners can deny services to applicants with more significant care needs (Armstrong et al. 2015, 107-108).

Research also indicates that the quality of care provided in for-profit privately owned facilities is often lower than that provided in public or nonprofit facilities, largely due to understaffing (Armstrong et al. 2015; Longhurst et al. 2020, Banerjee et al. 2015). One method used by researchers to measure this difference in quality of care has been by studying rates of formal complaints filed against different types of care facilities. In Ontario, an analysis of formal complaints made to the Ministry of Seniors and Accessibility regarding the quality of care provided in long term residential care facilities revealed that for-profit facilities were 1.5-2 times more likely to receive a formal complaint than publicly funded or nonprofit facilities. A similar study conducted in the Fraser Health region in B.C. revealed that for-profit facilities were 3-4 times more likely to receive formal complaints than nonprofit and publicly funded facilities (Armstrong et al. 2015, 108).

In understaffed long term residential care facilities, front line care workers are subject to unmanageably high workloads, inadequate time to provide necessary care, injury, and violence. Banerjee et al. (2015) describe the type of care provided in understaffed residential care homes as “assembly line care” (32). The care workers interviewed in Banerjee et al.’s study highlighted the “near impossibility of providing relational care” (ie. emotional support, social interaction, spiritual comfort) to residents due to the time constraints of their intense work loads. Workers described feeling frustrated and unhappy that they were unable to spend more time reassuring lonely or upset residents due to the need to provide intensive bodily care to a significant number of people in a short time frame. Physical body care is rushed, and interviewees reported that they were often unable to bathe or toilet residents as frequently as required to ensure health and wellbeing. As a result of critical understaffing and inadequate time to care, multiple Canadian residential care workers interviewed in another study stated that they were “unable to meet even the minimum essential care needs of the residents”, let alone provide emotional care (Daly and Szebehely 2012, 145-146). Care aides and personal support workers reported that their labour was organized by staff members who ranked higher in their organization’s hierarchy of power, and that their work was assigned as a series of discrete tasks on a tight schedule, with no room for flexibility or autonomy (Banerjee et al. 2015, 32). One care worker reported that some staff members came into the care facility during their time off to sit with dying residents to ensure they did not die alone, knowing that their coworkers who were on the clock would not have time to provide comfort or emotional support during a resident’s last hours (33).

The privatization of long-term residential care homes in Canada has not only impacted residents, but has also negatively affected job security, wages, and working conditions for care workers. In British Columbia, working conditions for long term residential care home workers

changed drastically throughout the early and mid-2000s because of a significant restructuring of employment relations within the sector enacted during the tenure of the provincial BC Liberal government. Under the previous BC NDP government, in the 1990s, unionized employees in long term residential care facilities formed a strong, unified bargaining agent called the Facilities Bargaining Association, which, under the leadership of the Hospital Employees Union, increased the bargaining power of workers within the sector. Through its negotiations with the Health Employers Association of BC, the Facilities Bargaining Association was able to secure consistent wages across the sector and prevent employers from contracting services out to private agencies. Care aides experienced relatively strong job security and fair wages; "in 1998, the starting wage for a care aide was about $19 an hour — more than double the $7.15/hour minimum wage at the time" (Longhurst et al. 2015, 107-108).

After the BC Liberal Government was elected in 2001, the strong collective agreement established by the Facilities Bargaining Association was quickly undermined. In January 2002, a bill entitled "the Health and Social Services Delivery Improvement Act" (Bill 29) was passed, which "unilaterally removed negotiated job security and contracting-out protections from master collective agreements, affecting approximately 100,000 workers in health care and social services" (Longhurst et al. 2015, 108). Bill 29 allowed members of the Health Employers Association of BC to lay off any existing staff defined as "non-clinical" staff, including care aides, who provide the majority of personal care within long term residential facilities, along with food preparation workers, service workers and cleaning staff (108-109). Once existing workers were laid off, their jobs could be contracted out to third party private agencies. New employees hired under these subcontracts would not have successorship rights, meaning they would not enter into the collective agreement held by the former employees they were hired to

replace. In the immediate aftermath of the passage of Bill 29, 9,000 unionized care workers — primarily women employed in food service, cleaning, and care aide positions — were fired (109-110). Some of these workers were later rehired into non-unionized positions as workers in third party agencies, but with significantly lower wages, worse benefits, and without the job security of their prior collective agreement. In 2003, the BC Liberal government passed Bill 94, which further solidified employers' ability to engage in "contract flipping", described by Longhurst et al. (2015) as a practice in which an employer can terminate a contract, lay off all subcontracted employees, develop a new contract offering lower wages and benefits, and hire a new subcontractor, replacing the old employees with a non-unionized workforce (112). The practice of contract flipping has resulted in high levels of staff turnover within residential care facilities: a phenomenon observed throughout Canada (Armstrong et al. 2015). Contract flipping is not only detrimental to the job security of care workers; it also has negative impacts on the quality of care provided to patients. High rates of staff turnover in long term residential care facilities are associated with higher rates of patient restraint, administration of psychotropic drugs, and occurrences of pressure ulcers (Armstrong et al. 2015, 111).

In addition to being overworked due to barebones staffing, care aides have also been subject to wage stagnation. According to the Government of Canada's Job Bank, in 2023, a care aide in BC can expect to earn between $19 and $25.85/hour ("Heath Care Aide in Canada" 2023). Some care aides today are earning no more than the average starting wage for their position in the 1990s. Given the significantly higher cost of living faced by workers across BC today, this wage is startlingly low for a high-risk position that is both physically and emotionally taxing.

In short, this important cluster of research has drawn attention to the impact of neoliberal policies on care provision in long-term care facilities, particularly those resulting in the privatization of care facilities, subcontracting of labour, and decreased influence of unions. This scholarship sheds light on some of the sector's most prevalent labour issues, highlighting the impact on both care providers and care recipients. While research on long-term residential care facilities is important, this work has dominated scholarly debates, even though a significant portion of care work for elderly people is provided by unpaid family members. In fact, unpaid caregivers are estimated to provide approximately 75% of all care services in Canada (Stall 2019, 245). Khayatzadeh-Mahani and Leslie (2018) argue that even though these unpaid family caregivers are often leveraged as a "key strategy in maintaining healthcare system sustainability worldwide", insufficient research has been conducted to analyze and assess the efficacy of programs intended to support unpaid caregivers (1). I help fill this gap in the literature by studying the interconnectedness of paid and unpaid care work.

My research draws on this important scholarship and contributes to it. First, my knowledge of the history of care and key challenges in the sector are informed by this rich historical and policy-oriented research. Second, this scholarship draws attention to the gendered, classed, and racialized history of care. However, there are some overall gaps in existing research. Much of the literature on care analyzes unpaid family caregiving *or* paid institutional or home caregiving for children, the elderly, and people with disabilities, without considering the important linkages between the two. Within the literature on paid caregiving, particular sectors are often analyzed in isolation from other forms of paid caring labour (ie. work on child care does not often reference work on elder care, and vice versa). This research aims to determine whether seemingly disparate policies regarding care are linked by a shared set of assumptions

and social narratives. Certainly, caregivers in different settings perform different types of labour and experience different conditions. The structural factors that compel one care worker to provide care may differ significantly from those that affect another. Nonetheless, the policies that regulate the work of temporary foreign workers providing paid care work and the policies that allocate financial support to Canadians providing unpaid care work are linked by a similar set of gendered assumptions about care and caregivers. A full picture of the care crisis cannot be attained without critically examining the links between paid and unpaid care and the workers who perform each type of caring labour.

The care crisis has generated attention in recent years, partly due to the global COVID-19 pandemic. The COVID-19 pandemic has highlighted the deep inequities and gaping holes within Canada's current distribution of care work and has intensified the need for contemporary research and innovative solutions to the deepening care crisis. My work engages with these important policy debates and argues that the care crisis cannot be resolved without first understanding the gendered and other assumptions about care that shape these policies. It is to these policies and their assumptions about care that we now turn.

Conclusion

The COVID-19 pandemic drew attention to the care crisis in Canada, but this crisis is not new. The care crisis has deep roots in policy decisions, in gender, class, and race relations, in funding priorities, and other issues. To begin to meaningfully address the care crisis, we need to have a deep understanding of some of the roots of the problem: the assumptions we make about care and those who provide it. Thus, my work examines the assumptions about care that underpin the policies that structure and regulate its provision. The aim of this chapter was to introduce my research questions, outline my approach and methodology, and provide an

overview of some of the most important and relevant scholarship in the field. This research project contributes to the existing field of literature on care in Canada by bridging the gap between the study of paid care work and unpaid care work. Further, the organization of care work is not only an academic issue, but one with real world significance and impact in the lives of many Canadians working as either paid or unpaid caregivers. Both unpaid family caregivers' and paid immigrant caregivers' experiences are shaped by policies that both reflect and reinforce gendered assumptions about the nature of care work and the people who perform it. Certainly, there are differences in the conditions that influence the labour of unpaid Canadian family caregivers and paid immigrant caregivers, and this analysis is not intended to flatten these meaningful differences. Nonetheless, both groups of care workers are subject to similarly gendered assumptions. Analyzing these two areas of policy with the intention of highlighting common underlying assumptions reveals the ways in which prominent gendered narratives about the provision of care shape the Canadian state's response to the care crisis and facilitate the continued prevalence of neoliberal policy responses.

Chapter One: Unpaid Caregivers in Canada — Unmet Needs and New Challenges

Introduction

In Canada, as in many other countries, a significant amount of care work is performed by unpaid family members or friends of the care recipient. Most of these unpaid caregivers are women. For instance, as feminist scholars show us (Glenn 2010; Federici 2004; Fraser 2014), the overrepresentation of women as unpaid caregivers is certainly linked to broader issues regarding social reproduction. However, what has not been clear from previous research is whether assumptions regarding care also contribute to the structure of specific policies addressing unpaid care. This chapter explores these issues by providing an overview and critical analysis of the available forms of direct financial support for caregivers in Canada, offered through EI. These specific policies are: the Employment Insurance Compassionate Care Benefit, the Employment Insurance Family Caregiver Benefit for Children, and the Employment Insurance Family Caregiver Benefit for Adults. I chose to analyze these policies because they represent one of the only avenues through which the Canadian federal government offers direct financial support to a small group of unpaid family caregivers who qualify. As will be discussed further in this chapter, these benefits are marginal and are inaccessible to a significant proportion of family caregivers. As a result, my analysis focuses not only on the textual content of the policies themselves, but also the broader policy context and impact of these policies, including their limitations and the ways in which they exclude a large majority of family caregivers. My analysis addresses not only what is present within these policies that allocate EI benefits to caregivers, but also what is missing.

This chapter begins with policy context, including an overview of each of these benefits, including their eligibility criteria and rates of compensation. Following this, I present my

research findings by discussing the key themes that emerged from my feminist critical discourse analysis of these policies. The chapter also provides analysis of other relevant information published by the Canadian government aimed at unpaid caregivers, including the financial advice for caregivers included alongside information about federal benefits and the publication "Balancing Work and Caregiving Duties: Tips for Employed Caregivers of Family or Friends", produced by the Federal, Provincial and Territorial (FPT) Ministers Responsible for Seniors Forum in 2016. As discussed in the introductory chapter, the tax credit available to Canadian family caregivers, the Canada Caregiver Credit, is not the primary subject of my analysis due to the limited availability of textual resources for analysis, but it will be briefly discussed in this chapter to contribute to a broader policy analysis of sources of federal funding for unpaid caregivers.

Policy Outline and Context

My analysis focuses on EI benefits for caregivers because they are currently the primary vehicle for direct federal financial support for unpaid family caregivers, and because of the availability of relevant texts regarding these policies. At the time of writing, the only province in Canada that offers a direct monetary allowance to unpaid caregivers (not tied to federal Employment Insurance benefits) is Nova Scotia, which offers eligible caregivers a direct monthly payment of $400. For caregivers in all other provinces, federal EI benefits and tax credits remain the primary potential sources of government support.

As noted, I focus on the Employment Insurance Compassionate Care Benefit, the Employment Insurance Family Caregiver Benefit for Children, and the Employment Insurance Family Caregiver Benefit for Adults. When discussing these benefits generally as a set of similar policies, I refer to them as "EI benefits for caregivers" or "EI caregiving benefits". The

Government of Canada also offers financial advice for caregivers seeking to apply for assistance. I will be treating this financial advice as a relevant source of discourse on unpaid caregiving originating from the Canadian state. One further source of state-produced discourse on unpaid caregiving is a publication entitled "Balancing Work and Caregiving Duties: Tips for Employed Caregivers of Family or Friends", produced by the Federal, Provincial and Territorial (FPT) Ministers Responsible for Seniors Forum in 2016. This publication is intended to provide advice to unpaid caregivers seeking to balance their paid work with their unpaid care work.

To understand the context of the policies and themes discussed in this chapter, it is first necessary to understand some key facts about caregiving in Canada. According to Statistics Canada's 2022 Canadian Social Survey, 29% of Canadians provide unpaid care for children, and 21% provide unpaid care for adults with care needs. Women made up the majority of unpaid caregivers; 32% of women surveyed reported providing unpaid care for children and 23% reported providing unpaid care to adults with long term illnesses or disabilities, as compared to 26% of men providing unpaid care for children and 19% providing unpaid care for adults ("More than half of women provide care to children and care-dependent adults in Canada" 2022). A higher proportion of Canadian women than men also reported being "sandwich caregivers", meaning that they provide care for both children and adults with care needs at the same time. Canadian women who report engaging in care work typically engage in higher-intensity and more frequent caregiving labour than male caregivers (Flagler and Dong 2010, 51). In a 2018 report from Statistics Canada, women also reported engaging in more hours of unpaid care work, making up 64% of caregivers who provided 20 hours of care per week or more ("Caregiving by the Hours, 2018" 2022). Statistics Canada's 2022 report explains this gendered difference in the intensity and volume of care work by providing information about the types of tasks performed

by caregivers of different genders. Women are more likely to perform caring tasks that must be completed daily or on a frequent schedule, such as personal care and hygiene or assisting with administration of medical treatments. Men, on the other hand, are more likely to perform maintenance work or complete outdoor chores that do not require daily or very frequent attention ("More than half of women provide care to children and care-dependent adults in Canada" 2022). With a significant majority of Canadian seniors living in their own homes, Canadian unpaid caregivers are estimated to provide around 75% of all care services, performing labour with an estimated market value of $24-31 billion annually (Stall 2019, 245).

Of the caregivers surveyed in Statistics Canada's 2018 General Social Survey regarding caregiving and care receiving, only 22% reported receiving any form of financial support for their caregiving duties (Hango 2020). 14% of the respondents reported receiving financial support from family members or friends. Only 6% of the caregivers surveyed reported receiving money from government programs, and only 8% reported receiving financial support through federal tax credits for caregivers. The overwhelming majority of caregivers in Canada received no financial support, and those who did were much more likely to receive it from private sources, such as family or friends, than from government benefits. In the same survey, caregivers were also asked if there was a form of support that they wished they had received to help meet unmet needs. 30% of respondents answered that yes, there was another form of support they would have liked to have received. Of the group of caregivers who reported desiring additional support for unmet needs, 68% reported that they wished they had received financial support, government-provided financial assistance or tax credits. Women reported that they had unmet caregiving needs at a higher rate than men (Hango 2020). A majority (56%) of unpaid caregivers reported feeling tired because of their caregiving labour, 44% reported experiencing anxiety, and

37% reported feeling overwhelmed. Women caregivers reported negative health and psychological consequences resulting from their caregiving responsibilities at a higher rate than men, with 62% of women reporting feeling tired (compared to 48% of men), 50% reporting anxiety (compared to 37% of men), 45% reporting feeling overwhelmed (compared to 27% of men), 35% reporting feeling irritable (compared to 26% of men), and 20% reporting depression (compared to 15% of men) ("More than half of women provide care to children and care-dependent adults in Canada" 2022). Caregiving is clearly not an easy task, and often comes with many complex challenges, especially when caregivers do not receive adequate support. These statistics serve to illustrate a fundamental challenge faced by many unpaid caregivers: overwhelming financial hardship with inaccessible and marginal government support. A very low proportion of caregivers report accessing federal benefits for their caregiving labour, while many report having unmet financial needs.

There are three types of EI benefits available for eligible caregivers who need to take time away from their jobs to provide care for a family member. The Family Caregiver Benefit for Children is available to those providing care for a "critically ill or injured person under 18". The Family Caregiver Benefit for Adults is available to those providing care for a "critically ill or injured person 18 or over". The Compassionate Care Benefit is available to those providing care for a "person of any age who requires end-of-life care" ("EI Caregiving Benefits: What these benefits offer" 2023). To qualify for caregiving EI benefits, a worker must have acquired at least 600 hours of insurable employment within the past 52 weeks prior to the start of their claim.

For a period during the COVID-19 pandemic, the threshold of insured hours required to receive EI benefits was temporarily lowered. In October 2020, after the end of the Canada Emergency Response Benefit (CERB), the Canadian federal government decreased the number

of insured working hours required to receive EI benefits to 120 hours of work within the 52 weeks prior to the start of a claim, allowing more Canadians to access EI benefits during a period where many had decreased working hours or were laid off. At the same time as this decrease in the number of required working hours, the federal government also "simplified rules around previous job separations in a way that benefited precarious workers" (Pasma 2022, para. 6). One year later, in October 2021, the number of insured working hours required to claim EI benefits was increased to 420 hours of work within the past 52 weeks prior to the start of a claim. This last temporary decrease ended on September 24, 2022, at which point the number of insured working hours required to claim EI benefits returned to its pre-pandemic threshold of 600 hours. The impact of this reduction in required insurable hours will be discussed later in this chapter.

These caregiving EI benefits are intended to supplement the income of workers whose earnings have decreased by at least 40% for 1 week or more due to the burden of unpaid care work. Caregivers who qualify for the Compassionate Care Benefit, the Family Caregiver Benefit for Adults, or the Family Caregiver Benefit for Children can receive up to 55% of their regular earnings, up to a maximum of $650 per week. Each of the three different EI benefits for caregivers has its own time limit: the Family Caregiver Benefit for Children can be accessed for up to 35 weeks, the Family Caregiver Benefit for Adults can be accessed for up to 15 weeks, and Compassionate Care Benefits can be accessed for up to 26 weeks ("EI Caregiving Benefits: What these benefits offer 2023). EI benefits for caregivers pay up to 55% of a caregiver's regular earnings, for a maximum of $650 per week.

As demonstrated by the statistics gathered by Statistics Canada's survey of Canadian caregivers, a large majority of unpaid caregivers in Canada are not accessing federal benefits to support their caregiving labour, despite many caregivers reporting a need for financial assistance.

The remainder of this chapter presents my research findings and analyzes the gendered assumptions embedded within the policies that allocate EI benefits to caregivers.

Findings and Analysis

Through my coding process, I identified a number of underlying gendered assumptions in EI benefits and related policies. First, care is defined within these policies as only a temporary need, rather than a long term or permanent commitment. Second, care work is taken for granted as less important than other, more "real" forms of labour. Third, caregiving labour is understood to be undeserving of adequate compensation; in the case of unpaid family caregivers, this is demonstrated through low rates of financial support through federal programs. Finally, care is portrayed as a private matter; in the context of unpaid caregiving in Canada, care is assumed to be a need best addressed by the care recipient's family members. I argue that these underlying assumptions, which I cluster as 'themes', have resulted in policies that fail to ensure the security and well-being of family caregivers and care recipients in Canada. As argued by Day (2013) social policies developed by governments that rely on the family model of care take the unpaid labour of women for granted, conceptualize care as a temporary and abnormal condition, prioritize other forms of labour over caring labour, and obscure the impact of state action and inaction on the ability of families to provide care.

Theme 1: Care as temporary

The policies that allocate EI benefits to family caregivers define care as a resource that is provided only on a temporary basis for individuals who are in an abnormal state of dependency. In Day's (2013) description of the family model of care, she claims that this model relies on a conceptualization of caring relationships as unidirectional — recipients of caring labour are

defined by their “abnormal condition” of dependency on support from another, while caregivers are defined as independent and free from any need for care themselves (23). In defining the experience of requiring care as abnormal rather than universal, the family model’s conceptualization of care is narrowed to only include care which is required as a response to a temporary change in an individual’s state of being, in which they undergo a transformation of their identity from independent to dependent. This restrictive understanding of the social relations of care obscures the complex realities of caring relationships and conceals the expansive range of activities and connections involved in providing and receiving care.

The conceptualization of care as a temporary and abnormal state of dependency is immediately evident in the definitions of care and care recipients found within the eligibility criteria for EI benefits for caregivers. Care is defined as “participating in the care of a critically ill or injured person or someone needing end-of-life care”, including both physical and emotional support (“EI Caregiving Benefits: What these benefits offer” 2023). While this definition of care explicitly includes emotional care work as well as physical care work, it is restrictive in defining this as something only provided to those experiencing critical illness or injury, or those who are close to death. A critically ill or injured person (the intended recipient of a caregiver’s support) is defined as “someone whose baseline state of health has changed significantly because of illness or injury. As a result, their life is at risk, and they need the care or support of at least 1 caregiver” (“EI Caregiving Benefits: What these benefits offer” 2023). The definition of a critically ill or injured person used in the eligibility criteria for EI benefits for caregivers explicitly excludes people living with chronic medical conditions, stating “[i]f the person is already living with a chronic medical condition, caregivers aren’t eligible for benefits unless the person’s health changes significantly because of a new and acute life-threatening event” (“EI Caregiving

Benefits: What these benefits offer" 2023). This definition in itself significantly restricts access to caregiving benefits for caregivers who support a loved one with a long-term illness or disability, simply due to the sustained nature of their care needs.

The conceptualization of care needs as temporary and abnormal is also reflected in the time limits imposed on EI benefits for caregivers. Each of the three different EI benefits for caregivers has its own time limit: the Family Caregiver Benefit for Children can be accessed for up to 35 weeks, the Family Caregiver Benefit for Adults can be accessed for up to 15 weeks, and Compassionate Care Benefits can be accessed for up to 26 weeks ("EI Caregiving Benefits: What these benefits offer" 2023). The time limits imposed on access to EI benefits for caregivers do not reflect the reality of caregiving in Canada. In Statistics Canada's 2018 General Social Survey on Caregiving and Care Receiving, caregivers were asked to identify each month within the past 2 years during which they had provided care for someone. 54% of respondents indicated that they had continuously provided care for the duration of all 24 months about which they were asked ("Differences in the characteristics of caregivers and caregiving arrangements of Canadians, 2018" 2022). This statistic demonstrates that the majority of Canadian caregivers consistently provide care for at least two years. While Statistics Canada only asked caregivers about the past 24 months, a study of unpaid family caregivers in the United States found that caregivers reported providing sustained care for an average of 4.6 years, with over 30% of caregivers reporting that they provided care for 5 years or more (Singer et al. 2010, 192).

The conceptualization of care as only a temporary need also creates conditions that lead to worker insecurity and precarity. In addition to the time limits imposed on EI benefits available to caregivers, each province also has its own employment standards law that mandates job-protected leave for care providers. In British Columbia, family responsibility leave, which is an

unpaid, job-protected leave of absence available to workers who need to take time off to provide care for an immediate family member, is only available for five days. The only other leaves available for caregivers are maternity/parental leave for parents of newborn infants and compassionate care leave, which allows workers to take an unpaid, job-protected leave of absence for up to 27 weeks in order to provide end of life care for a family member who has been given a medical certificate stating that they are likely to die within the next 26 weeks ("Leaves of Absence", 2022). Due to the limited nature of these job protections, many workers who must provide care for a family member for longer than five days may not be able to return to their jobs after their caregiving responsibilities have decreased or ceased. The lack of robust protections for workers with caregiving responsibilities means that workers may be treated as disposable and may lose their jobs if they are required to take more than five days off to provide care.

As Canada's population ages, the assumption that caregiving responsibilities are short-term responses to acute illness or injury becomes less tenable than ever. As of 2020, the Government of Canada reported that 73% of Canadian seniors aged 65 years or older have at least 1 of the 10 most common chronic diseases and health conditions ("Prevalence of Chronic Diseases and Risk Factors among Canadians aged 65 years and older" 2020). While each individual's experience of chronic illness may vary in severity and manageability, we can expect that many individuals living with chronic health conditions may require care to some extent, and that some may require significant daily care for a sustained duration of time. The unsustainability of a conceptualization of care as merely a temporary need reserved for the acutely ill or injured or those nearing the end of their life is heightened by the reality of the COVID-19 pandemic and the risk of post-COVID-19 syndrome, often called long COVID. Long COVID, which can

include symptoms such as severe fatigue, chronic respiratory problems, irregular heart rate, poor sleep, and "brain fog", has been described by some sufferers and experts as a "mass-disabling event" (Ziafati 2022; Mazer 2022). In a study conducted by Statistics Canada, 14.8% of Canadian adults (1.4 million people) who had contracted COVID-19 reported that they continued to experience symptoms three months or longer after their initial infection with the disease. ("Long-term symptoms in Canadian adults who tested positive for COVID-19 or suspected an infection, January 2020 to August 2022" 2022). Research on long-COVID remains in its early stages, but experiential accounts from those suffering from the long-term illness indicate that it can significantly decrease quality of life, limiting patients' ability to engage in cognitively challenging tasks, physical activity, and full-time work (Ziafati 2022). The emergence of long-COVID as a mass-disabling event is a striking reminder of an argument made by some scholars in the field of disability studies: for most of us, disability is an inevitable reality, and the privilege of being able-bodied is only temporary (Breckenridge and Vogler 2001; Pelka 2012). The prevalence of long-COVID reinforces this fact: we are all just one illness or injury away from experiencing a potentially life altering disability. As a result, the need for care is not abnormal or temporary, but universal and often ongoing.

The definition of care as a response to a temporary and abnormal state of dependency not only fails to reflect the practical lived realities of Canadian caregivers and care recipients, it also carries a significant ideological burden; it idealizes the notion of the independent, self-reliant individual. The conceptualization of human beings as self-sufficient and independent — one of the most fundamental tenets of liberal political theory — has been challenged by some feminist theorists, who argue that humans are interdependent, rather than entirely independent (Jaggar 1983; Pateman 1988). The concept of "individual freedom" is also at the centre of neoliberal

ideology (Armstrong 2013, 188). Feminist arguments against this depiction of humans as fundamentally independent, self-interested, and self-reliant tend to highlight the inherently social and interdependent nature of human reproductive biology, and of caregiving more broadly. The assumption of individual self-interest and self-sufficiency have been so central to liberal political theory that the existence of social community amongst human beings has been treated as a puzzle that must be solved through the development of social contract theory. However, if we are to imagine the "individual" as conceptualized by liberal political theorists, we must forget the inherently social processes of raising infants and caring for the ill, injured, and elderly — all of which are important processes to ensure the continued survival of our species. Relationships of interdependence and care are, therefore, not abnormal deviations from a self-reliant and fully independent norm. Caring relationships have always been, and will always be, a necessary component of human life.

It is clear that, in reality, caring relationships are not often merely temporary arrangements. The definition of unpaid care as a temporary solution to a temporary and acute problem conceals the need for sustained public investment in the social policy required to ensure that caregivers receive the recognition, financial support, and resources they need.

Theme 2: Care as less legitimate and valuable than other forms of labour

The second underlying assumption that underlines EI benefits for caregivers is the conceptualization of care work as less valuable and legitimate than other forms of work, particularly formal paid labour. Through my feminist critical discourse analysis and policy analysis, I found that there is a tendency for caregivers to be understood first and foremost as workers whose paid labour has been unfortunately disrupted by the burden of caregiving responsibilities. Care work is considered to be secondary in importance and skill to other forms

of work, and federal EI benefits for caregivers are structured in a way that incentivizes a quick return to formal employment and penalizes those who may need or want to prioritize their caring responsibilities for longer periods of time. No matter the importance or economic significance of care work, the labour of family caregivers remains undervalued.

One core aspect of the family model described by Day (2013) is that care is understood to be a burden to those who perform it, namely because it prevents them from fully participating in the labour market (2013, 24). In liberal welfare states like Canada, paid labour market participation is valued as the most legitimate form of work, and full-time employment is expected of all citizens who are able. Therefore, unpaid caring labour is conceptualized not as a social good in itself, but as a burden to be shed in order to return to the real work of paid employment (Fraser 1994, 604). Consequently, caregivers' access to financial support for their care work is dependent on their participation in the labour market. Caregivers are not valued sufficiently as legitimate and important workers in their own right, and caring labour is not appropriately understood as real work of significant economic and social value.

The most significant sources of financial support available to family caregivers in Canada are EI benefits, which are intended to partially offset income that a caregiver has lost by decreasing or temporarily ceasing their participation in the formal labour market. The Canadian state's decision to distribute most financial caregiving benefits through the framework of EI has significant implications for caregivers. According to Flagler and Dong (2010), benefits for caregivers often exclude many caregivers who are employed in non-standard forms of employment (such as part-time, contract, or temporary jobs, and many forms of self-employment) because they do not qualify for EI (55). This is particularly troubling given the interrelated and mutually reinforcing gendered dynamics of both caregiving and precarious

employment in Canada. Precarious labour is determined by a number of factors, including part-time hours, temporary contracts, inadequate wages, self-employment, employment at a business with poor adherence to regulatory measures, and lack of union membership, and is characterized by lack of autonomy, poor job security, and insufficient income (Lewchuk et al. 2008). In Canada, women have higher rates of participation in precarious forms of employment than men, particularly in temporary and part time employment (Vosko and Clark 2009). Participation in non-standard and precarious forms of employment is less likely to ensure that a worker has reached the threshold of insurable hours required in order to qualify for EI. As a result, across Canada, unemployed women are less likely to receive EI benefits than unemployed men (Flagler and Dong 2010). Further, Vosko and Clark (2009) also identify a correlation between women's disproportionate share of unpaid reproductive labour and their overrepresentation in precarious employment arrangements, arguing that women's ability to engage in permanent, full-time paid labour is impeded by their caring responsibilities, particularly child care responsibilities (34). As a result, women with caregiving responsibilities may find themselves trapped in precarious employment — they are unable to obtain financial support for their care work through EI benefits due to restrictive eligibility requirements, and they are unable to work enough hours in the labour market to qualify for EI benefits due to their caregiving responsibilities. Thus, the Canadian government's decision to administer direct financial support for caregivers through the framework of EI ensures that many Canadian caregivers (the majority of whom are women), will be unable to access benefits. It is also notable that "gendered precariousness is also racialized and shaped by immigration status in Canada" (Vosko and Clark 2009, 28). The heightened prevalence of gendered precariousness amongst racialized and immigrant workers in Canada is partly attributed to programs like the temporary foreign worker program discussed in detail in

chapter two, that constrain workers to precarious forms of temporary labour (Fuller and Vosko 2008). One consequence of such segmentation alongside changes in benefits, specifically tighter eligibility rules with the transition from the Unemployment Insurance Act to Employment Insurance in 1996, is that fewer part-time workers qualified for benefits or suffered a reduction in benefits. As research on labour precarity in Canada has shown, women and racialized workers tend to be overrepresented in temporary, casual and part-time employment, and thus often do not qualify for EI benefits (Vosko and Fuller 2008; Lewchuk et al. 2008). Due to the relationships between gendered precariousness, race, and immigration status, programs like EI, which often exclude workers in non-standard employment relationships, are often most inaccessible to racialized and immigrant workers, particularly women. This choice to allocate funding for caregivers primarily through Employment Insurance not only restricts access to financial support for many caregivers; it also indicates that informal caregiving labour is not valued by the Canadian state to the same extent as participation within the formal labour market.

In addition to the gendered nature of precarious labour, age is another relevant factor that may disqualify a significant number of caregivers from receiving support through benefits tied to participation in the labour market. As of 2018, 24% of Canadians 65 years of age or older reported that they provided care for a family member or friend living with a disability, physical or mental health condition, or challenges related to aging (Arriagada 2020). The median age for seniors who reported engaging in care work was 71 years of age. Senior caregivers were even less likely to report receiving financial support for their caregiving responsibilities from the Canadian government: only 5.2% of senior men and 4.0% of senior women reported receiving financial support for caregiving from government programs (Arriagada 2020). The coupling of

financial support for caregivers with EI means that senior Canadians who have retired from paid work in the labour market will be unable to access caregiving benefits.

As discussed in the first section of this chapter, during the peak of the COVID-19 pandemic, the Canadian federal government made some temporary structural changes to the eligibility criteria for workers seeking access to EI benefits. The number of insured hours of work required to access EI benefits was temporarily decreased, increasing accessibility to EI benefits for part-time, casual, or otherwise precariously employed workers. In a 2022 article published in the Canadian Union of Public Employees' (CUPE) quarterly magazine, *Counterpoint*, Chandra Pasma notes that in October 2020, when workers were able to access EI benefits with 120 insured working hours, 76% of unemployed women and 70% of unemployed men received EI benefits. In contrast, before the start of the COVID-19 pandemic, in January 2020, only 32% of unemployed women received EI benefits, compared to 45% of unemployed men. As the federal government increased the number of hours required to claim EI benefits once again after the first year of the COVID-19 pandemic, gender disparities in EI eligibility once again re-emerged, with a greater percentage of men than women accessing EI benefits. The closing of the gender gap within EI coverage that occurred as a result of the number of working hours required to claim benefits demonstrates one possibility for increasing the accessibility of caregiving benefits: by lowering the number of working hours required to claim EI, a greater number of caregivers could access benefits offered through this framework. However, simply lowering the number of insured working hours required to access caregiving benefits would not increase the benefits' accessibility to retired Canadians, as well as those who are unable to work within the labour market, or who have chosen or been required to work primarily or exclusively in unpaid roles.

The prioritization of caregivers' paid work within the labour market over their caring labour is also evident within the financial advice offered by the Government of Canada, both on the website outlining available EI benefits, as well as in the publication "Balancing Work and Caregiving Duties: Tips for Employed Caregivers of Family or Friends", produced by the Federal, and Territorial (FPT) Ministers Responsible for Seniors Forum in 2016. On the Government of Canada's "Benefits for Caregivers" website, carers seeking financial support from the Canadian government are encouraged to contact their employer, human resources manager, supervisor, or union representative to see if they are eligible for hybrid or remote work arrangements, adjustments to their working hours, paid or unpaid leave, coverage for medical expenses, or an Employee Assistance Program[2]. The Government of Canada also encourages caregivers seeking financial support to update their budget, noting that caregivers may experience financial hardship because of taking time off work to provide care to a loved one. The Government of Canada webpage, "Managing multiple financial priorities" seems to state the obvious: "Working fewer hours to care for someone who is ill could lower your income", noting that caregivers may find themselves unable to save for their retirement, or for a child's education[3]. Caregivers of seniors are urged to check if their loved one has a pension that may help financially support their care. Carers with teenage children are encouraged to compensate

[2] At the time of writing (February-March 2023) this information was available at: https://www.canada.ca/en/financial-consumer-agency/services/caring-someone-ill/benefits-tax-credits-caregivers.html Since then, this website has been archived. The archived site can be found here: https://web.archive.org/web/20220903180404/https://www.canada.ca/en/financial-consumer-agency/services/caring-someone-ill/benefits-tax-credits-caregivers.html. This is noted in the bibliography for this thesis.

[3] At the time of writing (February-March 2023) this information was available at: https://www.canada.ca/en/financial-consumer-agency/services/caring-someone-ill/managing-financial-priorities.html Since then, this website has been archived. The archived site can be found here: https://web.archive.org/web/20220809024129/https://www.canada.ca/en/financial-consumer-agency/services/caring-someone-ill/managing-financial-priorities.html. This is noted in the bibliography for this thesis.

for their inability to use savings for educational expenses by having teenage children pay for their own education by working (2022). In “Balancing Work and Caregiving Responsibilities: Tips for Employed Caregivers of Family or Friends”, unpaid caregivers who are also employed in the labour market are provided with similar advice. Caregivers are instructed to talk to their employer carefully and clearly, emphasizing that they have taken steps to “minimize the impact of [their] caregiving responsibilities on [their] work”, and are exhorted to “work with [their] employer” to arrive at an agreement that suits everyone (6). As in the advice offered on the Government of Canada’s webpages, working remotely is presented as a possible solution, as is using vacation time, personal or wellness days, or other leaves of absence. Carers are encouraged to “be realistic”, carefully minimizing the impact that their caregiving labour may have on their performance at work all while taking personal responsibility for their own emotional wellbeing to avoid allowing stress to impact their performance at work (4).

The language of this advice reflects and reproduces powerful ideological narratives about labour. By providing only minimal financial supports for unpaid caregivers who must take time off from paid work, encouraging caregivers to do all they can to avoid leaving the labour market, and leaving many forms of support within the jurisdiction of employers instead of government, the Government of Canada effectively hands off much of its responsibility to support unpaid caregivers onto employers and implicitly suggests that caregiving labour is less valuable than other forms of labour performed within the formal paid labour market. Caregivers are unable to access one of the primary sources of financial support offered by the Canadian government based on their caregiving labour in itself; rather they are only able to access this funding on the basis of their participation within the formal paid labour market. Care work, therefore, is unrecognized as real and valuable work in its own right.

Theme 3: Care as undeserving of adequate compensation

The third common assumption I identified in these policies is that care giving is not viewed as a legitimate form of work that is viewed as worthy of receiving adequate compensation. Currently, Canadian policies that distribute financial support to caregivers offer inadequate financial support that is both inaccessible and insufficient to support the ongoing financial needs of people with intensive caregiving responsibilities. The current financial supports available for caregivers are not intended as a long-term solution, but rather as a stopgap source of marginal financial support designed to partially reimburse workers for the loss of wages during a period in which they need to decrease their labour market participation. EI benefits for caregivers pay up to 55% of a caregiver's regular earnings, for a maximum of $650 per week, for a limited period. EI benefits for caregivers are not intended to fairly compensate caregivers for their valuable contribution, but rather, are intended to offer a temporary source of emergency funding designed to help caregivers survive a short period of acute caregiving. The limited and time-bound financial support offered through EI benefits incentivize caregivers to return to the labour market as soon as possible. As discussed earlier in this chapter, this is not often the reality for many caregivers, and long-term, ongoing care relationships are common.

Caregiving responsibilities can have a significant impact on an individual's financial stability, even for those who are able to remain employed. According to a report produced by the University of Alberta, a significant proportion of family caregivers have low incomes: 20% of employed family caregivers have an annual income of under $20,000, and another 23% have an annual income of under $40,000 (Betkowski 2023, para. 19). Workers receiving EI benefits can only receive up to 55% of their regular earnings; for those who already have low incomes, this may not be adequate to cover basic expenses like rent, transportation, and groceries. Workers

who are required to work fewer hours or leave paid employment as a result of their caregiving responsibilities not only face acute financial hardship, but also experience long-term, ongoing consequences, including reduced retirement savings and pensions. The report also notes that women caregivers are more likely than men to work fewer hours or leave the paid labour force entirely because of intensive caring responsibilities. The financial consequences of family caregiving are therefore extremely gendered, and women caregivers are most vulnerable to ongoing financial repercussions because of their caregiving responsibilities. The report concludes that EI benefits for caregivers are inadequate and fail to provide ongoing financial security (Betkowski 2023)

The underlying gendered narratives within EI benefits for caregivers link back to two of the questions posed in McPhail's feminist policy analysis framework (2003). First, McPhail's question: "Are women's unpaid labour and work of caring considered and valued or taken for granted?" is clearly relevant (55) As illustrated by the statistics provided in the introduction to this chapter, Canadian women bear the burden of the most intensive unpaid care tasks, and experience more negative health impacts from their caring labour than men. Women also experience more significant ongoing financial penalties for their unpaid caregiving labour. Glenn (2010) notes the extremely powerful social narrative that women are natural caregivers and that women "ought" to be the primary caregivers within their families, describing this belief as a "status obligation" (88). The assumption that care provision for family members is women's "duty" is so powerful that many people take it for granted that women should, and will, sacrifice their careers to perform unpaid care work for relatives in need (88). In the case of family caregiving in Canada, women bear the burden of financial and health consequences resulting from unsupported unpaid care work. Second, McPhail's (2003) question: "Where are the policy

silences? [...] What policy is *not* being proposed, discussed, and implemented?" is also relevant (58). Currently, Canadian federal policy does not offer any direct payments to caregivers on the basis of their caregiving work. Financial supports are either dependent on a caregiver's participation in the formal labour market, or they are indirect (in the case of tax credits).

As will be discussed later in this chapter, another potential source of financial support that some caregivers receive is the Canada Caregiver tax credit, which family caregivers can claim to reduce the amount of tax they must pay. According to Stall (2019), caregivers can only receive the tax deduction offered through the Canada Caregiver Credit if they have an annual income over a particular threshold. The credit is non-refundable and cannot be claimed by caregivers who do not earn sufficient income. As a result, low-income caregivers do not often receive financial support through the Canada Caregiver Credit (245). Direct payments to caregivers have been implemented in Nova Scotia, which allows caregivers to receive monthly payments of $400 ("Continuing Care" 2021), as well as in other countries, including the United Kingdom, which offers caregivers a weekly allowance of £76.75, equivalent to $129.30 CAD ("Carer's Allowance: How it works" 2023) and Australia, which offers an allowance of $144.80, equivalent to $128.01 CAD every two weeks ("Services Australia: Carer Allowance 2023). The implementation of federal policy that provides direct payments to caregivers has been recommended by the Canadian Centre for Caregiving Excellence (CCCE) in their 2022 policy whitepaper, "Giving Care: An approach to a better caregiving landscape in Canada". In addition to expanding the accessibility of tax credits and increasing financial supports for people with disabilities, the CCCE proposes the implementation of a federal caregiving allowance, both materially and ideologically. According to the CCCE, federally administered direct payments to

caregivers would serve both as a means to provide caregivers with a basic income and as a recognition of the value of caregiving labour to society (70).

Examining the forms of financial support available to caregivers in Canada through the lens of feminist policy analysis reveals that the unpaid labour of caregivers (particularly women caregivers) is taken for granted. Even though the economic value of unpaid caregiving labour in Canada is valued at $24-35 billion annually, caregivers cannot access direct federal funding for their caregiving work outside of EI payments. Other indirect sources of funding, such as tax credits, are often ineffective for low-income caregivers. The cost of living in Canada has climbed sharply in recent years, with significant increases to the price of food, transportation, and housing costs such as rent, and 26% of Canadians report that their household would be unable to cover an unexpected expense of $500 ("One in four Canadians are unable to cover an unexpected expense of $500" 2022). Caregiving often comes with significant unexpected costs; on average, unpaid family caregivers spend $5,000 out of pocket annually on care related needs, such as medical devices and medications that are not covered by insurance (Mesbah 2023). Family caregivers are inadequately supported by federal programming, despite the significant economic and social value of their labour. Current sources of federal funding do not provide sufficient ongoing support for unpaid caregivers.

Theme 4: Care as private

Finally, care is depicted as a private, personal responsibility in EI benefits for caregivers, rather than a social issue requiring significant public attention and investment. According to Day's (2013) description of the family model, the definition of care as a personal responsibility reinforces the notion that society can be divided into two dichotomous spheres: the private sphere, associated with feminized reproductive labour, and the public sphere (22-23). The

relegation of care to the private sphere has a number of significant consequences: unpaid care provided by family members — primarily women — is idealized as the most appropriate form of care and becomes associated with love, safety, and comfort. Social narratives that exile care to the private sphere contribute to the development of public policy that is "fractured" in nature. When care is imagined as a fundamentally private and personal need, the influences of the state and market on unpaid caregiving are concealed, and the need for public support of family caregivers becomes obscured (23).

Within the EI Family Caregiver Benefit for Children, the EI Family Caregiver Benefit for Adults, and EI Compassionate Care Benefits, unpaid caregivers are expected to have familial relationships with care recipients. Within the eligibility requirements for EI benefits for caregivers, a caregiver is defined as a family member of the care recipient, or someone whom the care recipient considers to be like family ("EI Caregiving Benefits: Do you qualify?", 2022). Caregivers are not required to live with the person to whom they are providing care, and do not need to be biologically or legally related, but the care recipient must attest that they are considered to be like a family member. While the definition of a caregiver within the eligibility criteria of these EI benefits is expansive and holds space for a wide variety of familial relationships outside the structure of a heteronormative, nuclear family, it retains the elevation of familial relationships over other social relationships, including social connections between friends and neighbours. As a result, the language used within EI caregiving benefits reinforces the location of care within the private sphere and the reification of familial relationships as the most appropriate relationships between caregivers and care recipients.

However, the use of a more expansive definition of family within the eligibility criteria for EI benefits for caregivers certainly allows for the recognition of a more diverse range of

caring relationships, including those outside of the heteronormative nuclear family. As observed by Knauer (2016), the concept of "chosen family" is often particularly relevant to LGBTQ+ caregivers and care recipients. LGBTQ+ seniors report receiving care from friends to whom they are not biologically related at a higher rate than heterosexual and/or cisgender seniors, often identifying these close friends as chosen family members. By utilizing a broad and inclusive definition of family within the eligibility criteria for EI benefits for unpaid caregivers, the Canadian government has made an important step towards recognizing caring relationships that fall outside the normative structure of the nuclear family.

Nonetheless, it is worthwhile to challenge the centrality of the concept of family to eligibility for caregiving benefits at all. If the Government of Canada is willing to look beyond restrictive legal definitions of family that rely on relationships of biology or marriage, why must EI benefits be limited to caregivers considered to be like family, rather than friends, neighbours, and any other community member who may have a caring relationship with the care recipient? By clinging to the notion of familial relation as central to caregiving relationships (both in the eligibility criteria for benefits, and in the names of the EI Family Caregiver Benefit for Adults and the EI Family Caregiver Benefit for Children), the Canadian state reinforces the conceptualization of care as a need best provided within the private sphere of the home by caregivers acting out of familial obligation.

Although this chapter primarily focuses on EI benefits for caregivers, it is relevant to mention the Canada Caregiver Credit, a tax credit available to some Canadian caregivers. The Canada Caregiver Credit is relevant here because it utilizes a different, much more narrow definition of family to judge a claimant's eligibility. Rather than the broad definition of family offered by the eligibility criteria for EI benefits for caregivers, the Canada Caregiver Credit is

only offered to those caring for a spouse or common-law partner, a child or grandchild of the caregiver or their spouse/common-law partner, or a parent, grandparent, brother, sister, uncle, aunt, niece, or nephew of the caregiver or their spouse/common-law partner ("Canada Caregiver Credit" 2023). This more restrictive definition of family excludes many caregiving relationships and fails to account for the myriad caring relationships forged outside the context of the nuclear family. Further, the inconsistency between the definition of family used to determine eligibility for EI benefits for caregivers and tax credits for caregivers highlights the fractured nature of Canada's support for unpaid caregivers. Unpaid caregivers attempting to navigate the complex systems of employment insurance and tax benefits may lack the knowledge, time, or energy to carefully explore and fully understand the different definitions of family used in each program. Caregivers who learn that they are ineligible for the Canada Caregiver Credit may assume that they are also ineligible for EI caregiving benefits without learning that the programs use different definitions of family to judge eligibility.

In addition to the centrality of family within eligibility criteria, the language used by the Government of Canada in its financial advice for unpaid caregivers also reflects a conceptualization of care as a private obligation, rather than a social issue requiring public funding. As discussed in the section of this chapter about the conceptualization of caregivers as workers first and foremost, the Government of Canada's advice for unpaid caregivers is primarily focused on encouraging caregivers to minimize the amount of time they must be absent from the labour market.

Another key concept reinforced by the Government of Canada's financial advice for caregivers is the language of personal responsibility and financial literacy. The term "financial literacy" is used to describe the knowledge and skills used by individuals to manage their money,

such as budgeting and saving. The use of the language of "financial literacy" in social policy is used to construct poverty as primarily the result of individual impoverished people's lack of information, skills, and education, rather than as primarily the result of structural inequalities (Montgomerie and Tepe-Belfrage 2016, 891). Policies that promote financial literacy as a solution to poverty reinforce the narrative that individuals experiencing financial hardship are not structurally disadvantaged, but merely financially illiterate and lacking the skills, knowledge, or willpower required to appropriately manage their money. The Canadian government's use of language that depicts caregivers' financial hardship as an individual problem resulting from money mismanagement or failure to adequately budget both reflects and reinforces the assumption that care, and its funding are private issues best addressed by the individual actions of a care recipient's family.

On the webpage "Managing multiple financial priorities", the Canadian state tells caregivers that one of the most important things they can do to decrease stress is to make a budget, and to update it when new financial obligations arise. Caregivers who are struggling financially while caring for a loved one are encouraged to "consider getting help with managing [their] finances or getting out of debt" by talking to a private financial advisor. The page includes a link to another state published resource titled "Making a budget" which offers advice such as: "evaulate your needs and wants" The Government of Canada reminds caregivers who are struggling financially that "a "want" is something that you'd like, but don't necessarily need. For example, meals at a restaurant, a trip, a gym membership, or designer shoes", and encourages them to refrain from buying themselves coffee. Caregivers are encouraged to take control of their financial situation by setting clear financial goals and eliminating frivolous spending on unnecessary luxuries. These tips are intended to help caregivers save money to prepare for

unexpected caregiving expenses. This advice assumes that low-income caregivers do not know how to manage their money; a class-related assumption reflected in some neoliberal social welfare policies.

The language used here clearly assigns the responsibility for financial struggle onto the struggling individual, rather than characterizing the financial hardships of unpaid caregivers as the result of structural factors, including inadequate support from federal programs. The Canadian state suggests that caregivers can avoid or mitigate the stress involved in caring for a loved one by making and sticking to a budget ("Costs associated with caring for someone who is ill" 2022). This suggests that experiencing financial hardship can be at least partially attributed to a lack of financial knowledge or failure to follow a budget. This assumption relies on the neoliberal logic present within the concept of "financial literacy". As argued by Santos (2017), by reducing the causes of poverty to inadequate financial education, neoliberal governments that promote financial literacy as a viable solution to financial hardship can rebuff critiques of the effectiveness of market-based policy solutions and instead chide impoverished citizens for their poor financial self-management. Governments that embrace neoliberal policies often promote financial literacy as a solution to impoverished people's struggles. This promotion of financial literacy reinforces a "culture of individual responsibility" and casts moral judgement on the household management of people experiencing financial hardship (418). Further, the moral judgement and allocation of blame embedded within the language of financial literacy is often implicitly gendered in nature (Montgomerie and Tepe-Belfrage 2016). Due to the feminized nature of social reproduction, women are often expected to purchase most household goods, and to ensure that costs remain within the household budget. Single female-headed households have been and continue to be used as a scapegoat for public fear, outrage, contempt, and ridicule

regarding the perceived threat of excessively high welfare costs. Political arguments that advocate for welfare state retrenchment often weaponize the image of the "welfare queen" — a term coined by Ronald Reagan to invoke a stereotyped image of an undeserving Black single-mother whose poverty can be attributed to wasteful spending habits and laziness (Hancock 2004).

By using the language of budget management and invoking the concept of financial literacy in its advice for struggling caregivers, the Canadian government essentially privatizes the financial challenges faced by unpaid caregivers. Caregivers who are experiencing financial hardship are not offered accessible and ongoing financial support for their caregiving labour, but rather, are given patronizing advice about eliminating designer shoes from their budget. The financial strain of caregiving is assumed to be the result of the caregiver's inadequate financial knowledge and skill, rather than because of policy failure. This assignment of blame onto individual caregivers' deficient financial literacy reinforces the neoliberal ideal of self-reliant individualism and legitimizes the state's inadequate financial support of unpaid caregiving.

The Government of Canada's financial advice for caregivers seeking support seems to patronize caregivers by assuming that they have not yet thought of making a budget and mitigating or eliminating unnecessary and luxury expenses. Using language invoking both the familial obligation of unpaid caregivers and their personal responsibility for their financial situation in the eligibility criteria for EI caregiving benefits, the Canadian government perpetuates the narrative that care is a private and individual issue, rather than a social need worthy of substantial public support.

As Day argues (2013), the depiction of care within social policy as a private and individual concern obscures the significant impact of state action and inaction on family

caregiving (23). By perpetuating the notion that care is an individual, rather than a social need, and is best served by family members without significant public support, the Canadian government fails to recognize the meaningful links between federal policy making and unpaid care provided within the home. Family caregivers' ability to provide care for their loved ones is significantly influenced by both the state and the market. Within the family model described by Day (2013), social policies fail to recognize the interrelated nature of family caregiving, state intervention, and market forces, instead reinforcing the "fictitious division between private lives and public matters" (23). Canadian federal policy supports the fictional notion that care is, and should be, a primarily individual and private matter by restricting available benefits to the family members of care recipients and by perpetuating the notion that financial hardship is the result of caregivers' poor individual choices and inadequate knowledge rather than the result of policy failures.

Conclusion

This chapter discusses and critically probes the assumptions underlying federal policies regarding access to EI benefits for caregivers and the financial advice offered by the Canadian government to those seeking to apply for benefits. I identified four core assumptions through inductive coding and then examined how these emerge and operate by re-examining these policies with reference to each assumption, presented as themes. My analysis reveals that EI benefits for caregivers rely upon the assumption that care is only a temporary need, and that caregiving responsibilities are only temporary in nature. The conceptualization of care as only a temporary, short-term need within Canadian federal policy results in ineffective and inaccessible financial support that fails to address the ongoing needs of caregivers, and extremely limited provisions for job protection. Second, care work is portrayed as secondary in legitimacy and

importance to other forms of work. Caregivers are not offered direct financial assistance based on their caregiving labour, but rather, on the basis of their work within the formal labour market. EI Benefits are only intended as temporary and partial income replacement before a caregiver returns to the formal labour market as soon as possible. Third, care is conceptualized as undeserving of adequate compensation. The Canadian federal government does not offer caregivers a direct allowance intended to support their informal caregiving labour on an ongoing basis, and many caregivers experience significant financial hardship. Fourth, care is depicted as a private concern and responsibility, rather than a social issue requiring meaningful and comprehensive public support. The labour of unpaid family caregivers (the majority of whom are women) within the home is taken for granted, and comprehensive public investment in supporting informal caregivers is not prioritized. Unpaid family caregivers are left with largely inaccessible, inadequate, and fragmented systems of financial support from the Canadian state, and, in turn, are blamed for their own financial struggles.

These gendered narratives are not separate from one another, but rather, are inextricably intertwined. These gendered assumptions all illustrate the ways in which care is systemically devalued within neoliberal policy. The unpaid caregiving labour of informal caregivers, most of whom are women, is inadequately recognized and financially supported by the Canadian federal government, despite its important social role, its contribution to the health care system, and its significant economic value. This research demonstrates the ways in which current Canadian federal policy both reflects and reinforces social narratives that conceptualize women's caring labour as a valueless and freely exploitable resource. As James Struthers (2013) argues, the growing burden of unsupported care for family caregivers has been frequently viewed by governments as "a policy solution rather than a policy problem", as unpaid family caregivers

pick up the slack caused by welfare state retrenchment (167). However, as illustrated by the statistics provided in the introduction to this chapter, inadequately supported caregivers often suffer from significant health and psychological challenges, including tiredness, anxiety, and depression. Treating unpaid caregivers as a policy solution for Canada's care crisis without ensuring that they receive adequate financial support is unsustainable.

In the following chapter, I discuss the ways in which these same assumptions are present in Canada's temporary foreign worker program stream for privately employed in-home care workers. Although the experiences of informal family caregivers and paid immigrant care workers are unique and distinct from one another, the policies that influence the conditions of their caregiving work both reflect and reinforce similar assumptions about the nature and value of care work and caregivers. The significance of these similar underlying gendered assumptions will be further developed and discussed in the following chapters.

Chapter Two: The Care Crisis Goes Global — Paid Immigrant Home Caregivers in Canada

Introduction

As women in Canada, as elsewhere around the world, entered the paid labour market en-masse (a trend which intensified throughout the last half of the 20th century), many are no longer able or willing to provide the sorts of unpaid care work that has traditionally been considered "women's work". Across much of the Global North, women's large-scale entrance into the workforce was not matched with adequate government investment into child care or elder care (Ehrenreich and Hochschild 2002, 8-9). This need for care provision has also not been adequately met by men (3). As a result, many families in the Global North, particularly those with relatively significant wealth, have sought out sources of caring labour in immigrant care workers from the Global South. As noted earlier and as will be discussed below, structural adjustment programs and other socio-economic issues in Global South countries combined with Canadian government policies that target particular "sending" countries has resulted in a high ratio of domestic care workers in Canada from Global South countries. This chapter focuses on the caregiver streams of Canada's Temporary Foreign Worker Program, which facilitates the immigration of privately employed, immigrant in-home care workers. As will be shown below, a similar set of assumptions about care shape these policies as was the case with EI policies. However, in slight contrast to EI policies, gendered assumptions are often intertwined with assumptions made on the basis of race and immigration status. But like the informal family caregivers discussed in the previous chapter, temporary foreign workers are both assumed to be disposable, low-skilled providers of a type of caring labour that is worth less than other types of work and is a private, rather than a public need.

This chapter is organised into two main sections. The first provides a brief overview of immigration streams and programs designed to facilitate the migration of immigrant care workers to situate my study, and provides a descriptive overview of the Home Child Care Provider and Home Support Worker Pilot Programs, outlining the core differences between these new programs and the former LCP. In this section I also compare the Home Child Care Provider and Home Support Worker Pilot Programs to their predecessor in order to assess the extent to which Canada's current immigration policies for migrant caregivers have effectively responded to criticisms of the LCP made by advocacy groups and scholars.

In the second section present my findings regarding the assumptions about care embedded in the Home Child Care Provider and Home Support Worker Pilot Programs. As in the previous chapter, I focus on four underlying gendered assumptions that I identified from my critical discourse analysis: care is conceptualized as temporary; care work is seen as secondary in importance to other, more "real" forms of labour; caregiving labour is understood to be undeserving of adequate compensation; care is portrayed as a private matter, rather than a social issue. As in the previous chapter, I use Suzanne Day's (2013) models of care as a framework for analysis. In contrast to the focus on the family model in the previous chapter, this chapter engages with Day's market model and medical model. Both models help us understand these programs and the ways in which the labour of immigrant care workers is undervalued.

Policy Outline and Context

For decades, Canada has had a number of immigration streams and programs designed to facilitate the migration of immigrant care workers to be employed privately within the homes of Canadians seeking child care, elder care, or care for individuals with medical needs. Currently, the migration of privately employed home care workers into Canada is facilitated by the Home

Child Care Provider and Home Support Worker Pilot Programs, which were designed as replacements for the former Live-In Caregiver Program (LCP), which operated from 1992-2014. Like the LCP, the current Home Child Care Provider and Home Support Worker Pilot Programs are streams of Canada's Temporary Foreign Worker Program. After the LCP ended in 2014, it was initially replaced by the Caregiver Program, which had two streams: the Caring for People with High Medical Needs stream, and the Caring for Children stream (Hanley, Larios, and Koo 2017). The Caregiver Program was operational for 5 years, until it was replaced by the Home Child Care Provider and Home Support Worker Pilot Programs in 2019. The Home Child Care Provider and Home Support Worker Pilot Programs are only intended to operate for 5 years, and are set to end in 2024. The Caregiver Program and the subsequent Home Child Care Provider and Home Support Worker Pilot Programs incorporated changes that responded to some major criticisms of the LCP, but also maintained some of its key features.

Canada's immigration streams for caregivers are notably gendered. Immigration streams designated for caregivers are almost exclusively used by women. Immigration, Refugees, and Citizenship Canada (IRCC) reports that in 2019, 94% of the individuals admitted through the caregiver streams were female. This disproportionate gender imbalance is not reflective of a general bias towards admitting female immigrants to Canada through all streams; in 2019, 57% of individuals admitted to Canada through the High-Skilled stream (consisting of the Federal Skilled Workers, Federal Skilled Trades, and Canadian Experience Class programs) were male, and 43% were female. In 2017, female applicants made up only 36% of admissions through the High-Skilled Stream ("Gender-based Analysis Plus" 2021). These statistics indicate that the overwhelming majority of immigrant care workers admitted through Canada's caregiver immigration streams are women, and that this gender bias is particular to the caregiver streams.

Hanley, Larios and Koos (2017) describe Canada's migrant caregiver programs as racialized, with a significant majority of care workers emigrating from states in the Global South; in particular, most care workers admitted through Canada's caregiver immigration streams come from the Philippines (124). According to Charie Siddayao, an organizer at the Philippine Women Centre of Ontario, as of 2017, 88% of care workers entering through Canada's caregiver immigration streams were from the Philippines (2021, para. 4). As a result, most participants in the Home Child Care Provider and Home Support Worker Pilot Programs are Filipina women (a fact that may be attributable, in large part, to the Philippines government's encouragement of outward labour mobility.[4]

The current Home Child Care Provider and Home Support Worker Pilot Programs were built upon the foundations of the former LCP, which was operational from 1992-2014.[5] The legacy of the LCP remains influential over policy regarding the migration and labour of immigrant care workers today. The discussion of the LCP and its subsequent replacements in this

[4] The prevalence of outward labour export from the Philippines can be significantly attributed to the Philippines government's historical and contemporary policies, which have embraced temporary labour migration as a response to domestic unemployment (O'Neill 2004). The country's labour export model was first codified in its 1974 Labour Code (Mendoza 2015). Since then, outward labour migration has become a foundational aspect of the country's economy; between 2010 and 2015, remittances sent back to the Philippines by migrant workers constituted, on average, 8.9% of the country's Gross National Product (GNP) (Mendoza 2015). In 2014, the Central Bank of the Philippines reported that remittances reached $27 billion (Mendoza 2015). The Philippines labour export model has helped to compensate for shortcomings in foreign direct investment and exports, but has also resulted in notable social issues, including brain drain, maltreatment of Philippine workers abroad, and a burgeoning care crisis of its own brought about by family separation (Mendoza 2015; Parreñas 2002).

[5] The LCP replaced the Foreign Domestic Movement Program (FDM). A longer discussion of the history of this program is beyond the scope of this thesis, but it is important to note some of the roots of these programs, particularly with reference to the countries that were targeted for domestic workers. For instance, the Live-in Domestic Worker Programs in Canada date back to 1955, when the West Indian Domestic Scheme was signed between Canada and the UK. The West Indian Domestic Scheme facilitated the immigration of Caribbean women to Canada to be employed as domestic workers. This scheme was replaced with the Employment Authorization Program in 1973, then the Foreign Domestic Movement Policy in 1979. Until the latter policy was introduced, domestic workers were not allowed to apply for landed status after their work permit expired. For a detailed discussion of the history of domestic worker programs in Canada, see Arat-Koc (1997).

chapter serves to illustrate both the changes and continuities within Canadian immigration policy impacting the lives of immigrant caregivers. The LCP was designed to import care workers to Canada to provide care for elderly people, disabled people, and children within the homes of care recipients. The program sought to fill gaps in the Canadian care economy that could not be filled by workers with Canadian citizenship or permanent resident status. According to the 1993 document "The LCP: Information for employers and live-in caregivers from abroad" published by Citizenship and Immigration Canada, the requirement that caregivers live within the homes of their employers was important because there was "no shortage of Canadian workers available for caregiving positions where there is no live-in requirement" (3). To be eligible for the program, caregivers were required to have successfully completed at least the equivalent of a Canadian high school education, to have at least six months of training or twelve months of experience in a field related to the caregiving work they would perform in Canada, and the ability to communicate through speech and writing in English or French. Care workers accepted into the LCP received a temporary employment authorization that allowed them to work for a single employer in Canada.

After two years (24 months) of employment in Canada as a live-in caregiver, care workers were able to apply for permanent resident status. After receiving permanent resident status, caregivers could be joined in Canada by their spouse and dependent children, given they passed all medical and background checks administered by Citizenship and Immigration Canada. Guidelines for caregivers and employers strongly recommended the establishment of an employment contract between parties, laying out the responsibilities of the caregiver, working hours, wages, charges for room and board for the caregiver, days off, details regarding the accommodations available to the live-in caregiver, and other conditions of employment. Within

its informational package for live-in caregivers, the Canadian state reiterates several times that it is not party to any contract brokered between an employer and a live-in caregiver, and that it is the responsibility of the live-in caregiver to learn the applicable labour laws that regulate their employment, and to manage any violations of employment standards by speaking to their employer or writing to an applicable provincial labour standards office. Under the LCP, workers' employment authorization documents were tied to one employer. Workers in the program could switch employers but were required to find a new employer and obtain a new employment authorization document from a Canada Employment Centre. Periods of unemployment could put a caregiver's ability to access permanent resident status at risk; the two years of employment as a live-in caregiver required to apply for permanent residency under the program's regulations were required to be completed within three years of their initial arrival in Canada (8).

The LCP closed in 2014, and was replaced by the Caregiver Program, which operated from 2014-2019. The Caregiver Program incorporated some important changes from the LCP; primarily, the requirement that workers live within the homes of their employers was removed. The Caregiver Program also separated care workers into two streams of employment: the Caring for Children Pathway and the Caring for People with High Medical Needs Pathway. These two streams were divided not only based on the nature of the care recipients, but also by the recognition of the workers' skill. Workers entering through the Caring for People with High Medical Needs Pathway were required to have education or training in healthcare provision at a college level, while workers entering through the Caring for Children Pathway were classified as "low-skilled" (Hanley, Larios, and Koo 2017, 127). Caregivers' employment authorizations remained tied to a single employer. In the reformed Caregiver Program, Citizenship and Immigration Canada also set annual caps on the number of applications for permanent residency

it would accept from program participants, accepting only 2,750 applications from each stream per year, for a total of 5,500 applications for permanent residency. This cap on applications for permanent residency was lower than both the number of workers entering Canada through the Caregiver Program and the number of applications for permanent residency accepted under the former LCP in the years prior (Hanley, Larios, and Koo 2017, 128). Workers who entered Canada through the reformed Caregiver Program were still required to work as live-in caregivers for two years before applying for permanent residency and were unable to bring their family members to Canada until their application was approved. This requirement — a continuation of the policy of the LCP — combined with the new limited caps on applications for permanent residency resulted in longer periods of family separation for caregivers.

Many scholars and immigrant rights activists critiqued the reformed Caregiver Program for its failure to substantively address the structural problems of the former LCP. For example, Banerjee, Kelly, and Tungohan (2017) argue that the "gendered and racialized nature of caregiving work and some of the legislated requirements of the LCP […] made caregivers particularly vulnerable to exploitation and abuse" (7). In 2019, the Caregiver Program's two streams — the Caring For Children Pathway and the Caring for People with High Medical Needs Pathway — were both closed to new applicants. In the place of the Caregiver Program, two new pilot programs were introduced: the Home Child Care Provider Pilot and the Home Support Worker Pilot. These pilot programs, set to remain in effect until 2024, have incorporated further reforms. According to the 2020 Annual Report to Parliament on Immigration published by Immigration, Refugees, and Citizenship Canada (IRCC), some of the key differences between the current pilot programs for care workers and previous caregiver immigration streams were implemented because of IRCC's engagement in a process that the government refers to as a

"Gender-based Analysis Plus", which was undertaken during the review of the Caregiver Program in 2018. IRCC's report describes "Gender-based Analysis Plus" as an "intersectional analytical process" used to assess the ways in which the intersections of sex and gender with other identities, including race, religion, ethnicity, ability, and age impact the effectiveness of federal policy (25). While no additional information is provided in the report regarding the actual process that took place, and how this process was consistent with a "Gender-based Analysis Plus" (GBA+) approach, the IRCC states that the reforms implemented into the Home Child Care Provider Pilot and the Home Support Worker Pilot attributed by IRCC to its GBA+ process include the replacement of employer-specific work permits with occupation-specific work permits, and the addition of a new element to the program wherein spouses and common-law partners of caregivers may receive open work permits to enter Canada with their partners, and dependent children may receive study permits to enter Canada with their parents. While these changes may be positive, and may indeed improve the experience of immigrant workers entering through the Home Child Care Provider and Home Support Worker Pilot Programs, it is unclear how exactly the application of GBA+ analysis resulted in the implementation of these policy changes.

Further, IRCC's 2020 report to Parliament states that under the current Home Child Care Provider Pilot and Home Support Worker Pilot, applicants are assessed for their eligibility for obtaining permanent residency before they begin their employment in Canada. The report states that this change is intended to reduce application processing backlogs and minimize time spent waiting in limbo between completing the required period of work as an in-home caregiver in Canada and receiving permanent residency status. While the adoption of GBA+ analysis has been mandated by the Canadian federal government for all ministries, some scholars argue that

some of the changes made to the Temporary Foreign Worker Program have been the result of advocacy work and activism, often led by Filipina women with lived experience as migrant care workers (Tungohan 2018).

One new condition required by the Home Child Care Provider and Home Support Worker Pilot Programs not discussed in IRCC's 2020 report to Parliament is the imposition of new education and language requirements. As mentioned in the above description of the LCP, from 1992-2014, immigrant care workers were required to have an education equivalent to a Canadian high school education. After the implementation of the 2014 Caregiver Program, workers entering through the Caring for People with High Medical Needs stream were required to have some post-secondary training, while workers entering through the Caring for Children stream were not. Currently, eligible applicants to both the Home Child Care Provider Pilot and the Home Support Worker Pilot Programs must have either a Canadian post-secondary credential for a program at least 1 year in length, or a "foreign educational credential equivalent to [the aforementioned Canadian credential] *and* an Educational Credential Assessment (ECA) report issued for immigration purposes by an organization designated by IRCC" ("Home Child Care Provider and Home Support Worker Pilot: Assessing the application against selection criteria" 2022, para. 2). To be eligible, post-secondary credentials issued outside Canada must have been issued no more than 5 years prior to the care worker's application to either pilot program. It is noteworthy that prior to the introduction of this requirement, most immigrants entering through Canada's caregiver immigration streams already had post-secondary education. In 2013, about 60% of entrants through the LCP held at least a bachelor's degree (Banerjee, Kelly, and Tungohan 2017, 9).

The current pilot programs also seem to have raised the language requirements for applicants. According to the 1993 document "The LCP: Information for employers and live-in caregivers from abroad", caregivers entering Canada through that program were required to have sufficient knowledge of English or French to "function independently in a home setting", particularly emphasizing practical skills such as communicating with emergency services and reading and understanding medication labels to ensure appropriate dosage (3). According to the information provided on the IRCC website, the current Home Child Care Provider and Home Support Worker Pilot Programs require successful applicants to submit test results from an approved testing organization to demonstrate that they have achieved "a language proficiency of level 5 in the Canadian Language Benchmarks or the Niveaux de compétence linguistique canadiens" in the categories of reading, writing, speaking, and listening ("Home Child Care Provider Pilot and Home Support Worker Pilot: Language requirements" 2022). Level 5 in the Canadian Language Benchmarks system is classified as an "intermediate" level of fluency and is higher than level 4 ("fluent basic") which is currently the required level of language proficiency required for individuals applying for Canadian citizenship ("Canadian Language Benchmark (CLB) Descriptions" 2023; Singer 2018).

Since I began writing this thesis, another change to the Home Child Care Provider Pilot and Home Support Worker Pilot has been announced. On February 10, 2023, members of Parliament Salma Zahid and Rechie Valdez announced on behalf of Sean Fraser, Minister of Immigration, Refugees, and Citizenship Canada that the required duration of work in Canada for caregivers to become eligible for permanent residency would be halved, from two years to one. This change has been implemented as of April 30, 2023, and will be applied retroactively to workers who have already applied for permanent residency. A press release issued by the

Members of Parliament states that this change is intended to hasten IRCC's processing times to allow caregivers to obtain permanent resident status in a timelier manner. The press release also states that discussions regarding the future of caregivers' immigration to Canada are underway as the pilot programs near their scheduled conclusion in June ("Canada to reduce work experience requirements for caregivers and provide pathways to permanent residence" 2023).

Findings and Analysis

A range of changes have been introduced to federal policies regarding domestic care. As noted, some of these changes respond to critiques of the program by advocacy groups, scholars and foreign domestic workers themselves. While it is too early to trace the actual impact of these policy changes on workers, their working conditions and their path to immigration, these changes were certainly important and necessary. But the question remains: will policy changes from the end of the LCP to now, including the introduction of the current Home Child Care Provider and Home Support Worker Pilot Programs fundamentally challenge and change working conditions and the ways in which immigrant home care workers are viewed? A decisive answer to this question might not be possible, but an assessment of the underlying assumptions about care in these policies might hint to how transformative, or not, these policy changes are. I turn to that policy assessment now, exploring four gendered assumptions about care and care workers. As noted, this analysis will, in part, build upon Suzanne Day's (2013) descriptions of both the medical and market models of care to illustrate the ways in which care workers are exploited workers within the neoliberal care economy.

Theme 1: Care as temporary

In the previous chapter, I discussed the conceptualization of care as a temporary need, only required in abnormal and acute circumstances. In the case of the Home Child Care Provider and Home Support Worker Pilot Programs, the theme of temporariness is present in the ways in which immigrant care workers are treated as temporary and disposable. Despite the promise of permanent residency within the Home Child Care Provider and Home Support Worker Pilot Programs, many immigrant care workers are subject to extremely prolonged waiting periods, and are often required to reapply for temporary employment permits multiple times. Consequently, the Home Child Care Provider and Home Support Worker Pilot Programs often subject immigrant care workers to protracted periods of multiple years in which they retain the status of a temporary foreign worker. By failing to grant these workers permanent resident status in a timely fashion, the Canadian state confines immigrant care workers to a period of prolonged temporariness, in which they are unable to access the settlement services available to immigrants entering Canada through channels other than the Temporary Foreign Worker Program, including language lessons, job training, and career search support ("Welcome to British Columbia: Information for Temporary Foreign Workers in British Columbia" 2023). The promise of a pathway to permanent residency incentivizes qualified care workers to the Home Child Care Provider and Home Support Worker Pilot Programs, but many of these workers find themselves subject to unreasonably long wait periods in which they are subject to the precarity and uncertainty of temporary foreign worker status. Certainly, delays are experienced by many individuals seeking permanent residency, including those outside the Home Child Care Provider and Home Support Worker Pilot Programs, and outside the broader Temporary Foreign Worker Program. However, as discussed later in this chapter, workers within the Home Child Care Provider and Home Support Worker Pilot Programs experience several conditions that amplify

the precarity of their work, including isolated workplaces in which they are often the sole employee, limited occupational mobility, and very low wages. Some advocates highlight these factors, arguing that participants in the Home Child Care Provider and Home Support Worker Pilot Programs who experience prolonged periods wherein they hold only temporary foreign worker status have a higher risk of exposure to emotional, physical, and sexual abuse from employers, as well as other forms of exploitation in the workplace (Keung 2021; Siddayao 2021). As such, long delays in the processing of permanent residency applications by participants in the Home Child Care Provider and Home Support Worker Pilot Programs may result in particular challenges for this group of workers, who experience heightened labour precarity.

According to comments made in House of Commons Debates, many immigrant care workers within Canada, as well as applicants to the pilot programs who are awaiting approval of their applications in their home countries have expressed frustration and feelings of neglect as a result of excessively long wait periods for bureaucratic processing of applications (HC Deb 89 June 2022). Many of the changes that have been made to the Home Child Care Provider and Home Support Worker programs in recent years have been implemented with the stated goal of reducing processing times for permanent residency applications and mitigating the harm of extended periods of family separation. However, processing delays appear to remain a significant issue for caregivers applying for both work permits and for permanent residency status through the Home Child Care Provider and Home Support Worker Pilot Programs.

Backlogs and delays in processing have often been attributed to the global COVID-19 pandemic; however, these issues appear to predate the start of the pandemic. Recently, IRCC has faced criticism after the release of data indicating that almost 60,000 open, pending, or re-opened

applications are currently assigned to “inactive users” within their case management software, with some applications assigned to employee codes that have not been active for over a decade (Hwang 2022). Although IRCC has defended the practice of assigning applications to inactive employee codes as part of their triage system, many immigrants whose applications were assigned to inactive users have reported that they had not received any updates about their applications for years.

In an article written in May 2021, Regulated Canadian Immigration Consultant Marjorie Carmona Newman wrote that she had submitted applications to the pilot programs on behalf of several clients since their introduction in 2019, and no clients had received work permits (Newman 2021). This claim is echoed by Vancouver-based immigration lawyer Deanna Okun-Nachoff, who stated in 2021 that she had not seen a single work permit approved, despite providing legal assistance to many prospective immigrant caregivers (Keung 2021). Steven Meurrens, a Vancouver-based immigration lawyer who has made access to information requests to obtain data from IRCC, reports that IRCC received 24,725 applications for work permits through the Home Child Care Provider and Home Support Worker Pilot Programs between the program’s start in 2019 and March 31, 2022, but only processed 2,494 of these applications (2023, para. 21). This indicates a serious backlog in processing at IRCC; in the first three years of the Home Child Care Provider and Home Support Worker Pilot Programs, over 90% of applications submitted by prospective care workers remained unprocessed. According to Toronto Star reporter Nicholas Keung (2021), *zero* work permits were issued through the Home Child Care Provider and Home Support Worker Pilot Programs between the program’s start date in June 2019 and November 2020. Keung (2021) reports that application processing for caregivers

applying through these programs occurred “at a snail’s pace”, even before the pandemic and lockdown measures resulted in decreased staffing at IRCC (para. 5).

Caregivers who have successfully received work permits and completed the period of required Canadian work experience as in-home care workers also face long wait times when they apply for permanent resident status. Keung (2021) reports that between January 2019 and November 2020, IRCC received 13,230 applications for permanent residency from immigrant caregivers, but only processed 4,140 applications, with an approval rate of 74%. This also reflects a lower approval rate than the former LCP, under which over 90% of applicants received permanent residency status after completing the required work experience (Keung 2021). The backlog of caregiver applications remaining unprocessed has been noted in parliamentary debate. On June 15, 2022, MP for Vancouver East Jenny Kwan spoke of the processing backlog for applications to IRCC in general, and to the caregiving streams in particular. Kwan told Parliament that migrant caregivers in her constituency, the majority of whom are women “feel neglected and unimportant”, and feel that they “are being pushed to the backburner” by the federal government (HC Deb 89 June 2022)

It is clear that caregivers’ experiences of the Home Child Care Provider and Home Support Worker Pilot Programs are marred by long wait times which delay their transition to permanent residency, leaving them subject to the limitations of temporary foreign worker status for unreasonably long periods. Delays in processing and decreased approval rates for permanent residency applications mean that, despite the implementation of reforms, the Home Child Care Provider and Home Support Worker Pilot Programs fail to provide a clear and timely path to permanent residency for immigrant caregivers in Canada, and relegate many immigrant care workers to precarious labour and temporary foreign worker status for long and indeterminate

periods of time. By failing to grant immigrant care workers with the permanent residency offered as an incentive for participation in the Home Child Care Provider and Home Support Worker Pilot Programs in a timely manner, the Canadian government enforces precarity and temporariness for immigrant home care workers. While the significant delays in the granting of permanent residency to temporary foreign workers may reflect issues of resource allocation, institutional inefficiency, and implementation, rather than policy content, these issues remain relevant to my analysis as they demonstrate the fact that policy reform requires adequate government investment in resources to ensure timely and effective implementation. In her feminist policy framework, McPhail (2003) points this out by inviting researchers to ask: "Is the policy merely symbolic or does it come with teeth? Are there provisions for funding, enforcement, and evaluation?" (57). Until the Canadian government allocates adequate resources to processing applications for permanent residency for applicants within the Home Child Care Provider and Home Support Worker Pilot Programs, policy reforms intended to hasten this process will continue to fall short.

Theme 2: Care as less legitimate and valuable than other forms of labour

Canada's Home Child Care Provider and Home Support Worker Pilot Programs reflect and reinforce the idea that care work is less legitimate, valuable, and skilled than other forms of labour. The in-home care work provided by immigrant care workers is often treated as an extension of the type of taken for granted socially reproductive labour performed by women in the homes of their families and is similarly undervalued. In this section, I discuss Canada's TEER system (which the federal government uses to define occupations as high or low-skilled), the social narratives that construct notions of skilled and unskilled labour, the barriers to credential recognition faced by immigrant workers, and the narrative of immigrant labour as a

"sacrifice" within government texts. I discuss these key points in order to highlight the ways in which the labour of immigrant home care workers is defined in policy as unskilled, less valuable than other forms of work, and inadequately recognized as legitimate work.

One way in which care work is constructed as less valuable than other forms of work is its persistent definition as unskilled labour, despite the qualifications of those who perform it and the reality of its complex demands. Many immigrant care workers entering Canada through the Home Child Care Provider and Home Support Worker Pilot Programs experience a process of deskilling. The International Organization for Migration defines deskilling as "a situation in which migrant workers occupy jobs not commensurate with their qualifications and experience" (2012, 14). Deskilling is also sometimes referred to as downward occupational mobility, over-qualification, or underemployment. Deskilling often occurs when immigrant workers are employed in occupations considered to require lower levels of skill than that for which they are qualified.

The Canadian government conceptualizes labour within a hierarchical structure, wherein particular occupations are considered more or less skilled. Some immigrants who are considered to be more highly skilled may be granted permanent resident status through expedited processes, while immigrants who are considered low skilled (regardless of the importance or demand for their labour) are often relegated to temporary employment in Canada with delayed access to permanent residency, or with no guarantee of permanent residency at all. Despite the addition of new post-secondary education requirements to the Home Child Care Provider and Home Support Worker Pilot Programs, and the fact that the majority of immigrants admitted through the program hold at least a bachelor's degree (Banerjee, Kelly, and Tungohan 2017, 9), in-home caregiving occupations remain classified as low-skilled labour in Canada.

Canada's National Occupation Classification system (NOC) sorts occupations into categories using a system called TEER, meant to indicate the level of training, education, experience, and responsibilities required for workers in each occupation. The TEER system was implemented in 2016 and is used as the basis upon which immigrants are deemed to be high-skilled or low-skilled workers. Both home child care providers (NOC 44100) and home support workers (NOC 44101) are classified as TEER 4 occupations. Occupations in TEER 4 are described as typically requiring workers to have completed a high school education, or to have completed training in the workplace for their occupation ("National Occupation Classification (NOC) 2021 Version 1.0" 2021). Occupations in TEER 4 are excluded from all of Canada's Express Entry immigration streams, which are described as programs intended to admit "skilled workers based on their skills and ability to contribute to Canada's economy" ("Eligibility for Express Entry programs" 2022, para. 1). Unlike tradespeople employed in the male-dominated resource extraction industry, who are eligible for the Federal Skilled Trades Express Entry program, caregivers are classified as low-skilled workers whose contribution to Canada's economy does not grant them access to immediate permanent residency. The classification of caregiving labour in TEER 4 of the NOC is also incongruous with the education requirements of the Home Child Care Provider and Home Support Worker Pilot Programs, which require immigrant home care workers to have completed and received a credential for a post-secondary program of at least one year in length. Immigrant care workers are expected to have earned a post-secondary credential that should make them eligible for work classified as more highly skilled than the occupations included in TEER 4 but are ineligible for permanent residency until they have completed a period of employment in an occupation classified as low-skilled.

It is worth noting that, despite the classification of home child care and home support work as unskilled occupations, both home child care providers (NOC 44100) and home support workers (NOC 44101) are expected to perform both physical and social tasks that require practice, flexibility, responsiveness, and patience. The NOC provides a description of the tasks included in each occupation. Home child care providers are expected to perform a wide variety of tasks, including supporting the "social development" and "emotional well-being of children", disciplining children, providing "age appropriate educational training through organized activities", planning and preparing meals, and ensuring the child[ren]'s safety within the home ("44100 - Home child care providers" 2021, para. 5). Home support workers are expected to perform an equally varied set of tasks, including providing "care and companionship", assisting clients with personal hygiene (including bathing and toileting), preparing meals according to special diet plans, and performing various "health related duties" such as dispensing medications, changing bandages, and "collecting specimens" ("44101 - Home support workers, caregivers and related occupations" 2021, para. 5

The concepts of skilled and unskilled labour are not value-neutral, and the arrangement of different types of labour within a hierarchy of skill erases the ways in which labour that is typically considered low-skilled or unskilled is necessary work and contributes considerable social value. According to Pat Armstrong (2013), "skills are socially defined and constructed", shaped by power relations, as well as by gendered assumptions, and sometimes, by racist stereotypes (102). Care work is often constructed as unskilled work, and the skills employed by care workers are often assumed to be natural and innate, rather than learned and practiced. Armstrong argues that within health care, boundaries are often constructed around "medical work", which is understood as the set of clinical skills acquired through higher education used to

treat bodily ailments through biomedical intervention (105). Medical work is typically performed by highly paid, high-status health care professionals like doctors, and many men perform this type of labour. Medical work is understood in contrast to what Armstrong calls “social care”, which consists of the types of activities often performed by home support workers, such as support with toileting, bathing, eating, and emotional care and support (105). Social care — while it may not require the same sorts of technical clinical skill as some other forms of medical care, such as surgery — requires workers to exercise learned and practiced relational skills. Many of the skills listed in the NOC descriptions of these occupations require the application of social and relational skills that may not be immediately visible. Armstrong (2013) writes that a task like bathing a patient “may seem like a simple task of applying water to skin”, but may be quite complicated, as the care worker must persuade the patient to allow them to bathe them and ensure that the patient is comfortable and safe throughout the process (102-103). Care workers will often develop specialized techniques to perform both physical and emotional tasks: for example, they may have practiced methods of safely lifting a patient who resists being moved, feeding a patient who often refuses food, or comforting a patient who must undergo an uncomfortable medical procedure (103). Home care workers also incur a significant responsibility for care recipients: a home child care provider must be constantly attentive to ensure the safety and well-being of the children in their care, even in unpredictable circumstances. Care work, therefore, requires significant skill, often in ways that may be invisible to outsiders.

Armstrong argues that social care is often devalued and considered to be low-skilled or unskilled labour because in some ways, it appears to be similar to the reproductive labour and housework performed by women within the home. The tasks involved in social labour are often

assumed to require only "the sort of soft skills that most women know how to do by virtue of being women"; as a result, social labour is often considered not to be real work (105). The assumption that in-home care work is low-skilled or low-value because of its proximity to the type of socially reproductive labour assumed to be natural for women also reflects one of the questions asked by McPhail (2003) in her feminist policy analysis framework. McPhail asks: "Are women's unpaid labour and work of caring considered and valued or taken for granted?" (55). While the labour of in-home care workers is not unpaid, the perception that it is like the undervalued and unpaid care work performed by women in their homes contributes to its devaluation and the persistent assumption that it is unskilled in nature.

Armstrong's description of the ways in which the neoliberal health care system separates high-status medical work from low-status social labour reflects Suzanne Day's conception of the medical model of care. According to Suzanne Day (2013), within the medical model, care is defined narrowly as biological treatment for bodily ailments performed by medical experts with professionalized status (25-26). Within this model, emotional care is devalued, and physical care work considered to be simple manual labour is valued least of all. The medical model therefore excludes many forms of care work, especially care for people whose care needs cannot be "cured" through medical intervention, such as individuals living with chronic health conditions and elderly people who require long-term support for daily living (Day 2013, 25). The narrow definition of skill within health care as only applying to complex biomedical treatment serves employers by allowing them to cut costs by primarily hiring low-waged workers whose labour is defined as low-skilled (Armstrong 2013, 103-104). As will be discussed in greater detail later in this chapter, professions such as nursing often require practitioners with foreign educational certifications to complete further educational programs in the countries to which they migrate in

order to have their credentials recognized. These barriers to recognition often push immigrant health care professionals into low-status care work that is assumed to require few skills. When social care is provided within the patient's home, as is required by the conditions of the Home Child Care Provider and Home Support Worker Pilot Programs, the skill exercised by the caregiver is obscured even further, as the setting of the labour replicates the setting of unpaid reproductive labour (105-106). As a result, the skills of immigrant home care workers are often unrecognized.

Immigrants often experience deskilling because of barriers to recognition of education and credentials received in their country of origin. The need for recognition of credentials is a particular barrier in regulated professions (occupations wherein practitioners are required to hold a particular certification and receive recognition from a governing regulatory body), such as nursing (International Organization for Migration 2012; Bourgeault et al. 2010; Hawkins and Rodney 2015). In fact, many immigrant women who come to Canada as care workers through the caregiver immigration streams are licensed as nurses in their countries of origin (Bourgeault et al. 2010, 88). Many women opt to enter Canada through the caregiver immigration streams, despite holding credentials that make them eligible for occupations recognized by the Canadian government as more highly skilled than caregiving work due to the time and money required to complete education programs required to receive recognition for credentials obtained outside Canada (88). This trend is noted by Charie Siddayao of the Philippine Women Centre of Ontario, who claims that Canada's caregiver immigration programs "target" healthcare workers from the Philippines who have extensive education and experience, and that Canadian labour policies then prevent these highly qualified health care professionals from practicing within their occupations in Canada, instead deskilling them by limiting them to the low-waged and low-status support

work and child care occupations (2021, para. 4). One participant in a 2015 study of nurses from the Philippines shared her experience of seeking licensure in Canada stated: “I would not be able to take [the re-entry program] because, you know, it’s very hard for me to be feeding four mouths, and then I’ll be studying” (Hawkins and Rodney 2015, 104). Another barrier to academic upgrading identified by the Congress of Progressive Filipino Canadians (2018) is the cost of international student tuition, which is much higher than domestic student tuition. Post-secondary education and credentials received outside Canada are devalued, and recertification and licensure are often unattainable to immigrant workers who must prioritize their immediate financial needs and those of their family members.

Many immigrants who enter Canada through caregiver immigration streams remain in poorly compensated home care work even after they have completed the required period of employment as a home care worker in Canada. While most research on the labour market outcomes of immigrant care workers in Canada was conducted in the context of the LCP, a number of factors responsible for the limited occupational mobility of care workers are also relevant in the context of the current Home Child Care Provider and Home Support Worker Pilot Programs. Regardless of their credentials and qualifications, participants in the Home Child Care Provider and Home Support Worker Pilot Programs are required to gain Canadian work experience as home care workers. As described above, home care occupations are considered by the Canadian state to require only low-skilled labour. According to Banerjee, Kelly, and Tungohan (2017), even after care workers complete their required period of work in home care and obtain permanent residency, Canadian employers in other industries often continue to perceive participants in caregiver immigration programs as best suited for poorly compensated and low-status home care work because of the worker’s most recent employment experience, as

well as racial discrimination and stereotyping (11). Another barrier to occupational mobility amongst workers who enter Canada through caregiver immigration programs is the limited social network available to them due to their work taking place inside their employer's home. Until obtaining permanent residency, due to their classification as temporary foreign workers, immigrant care workers are also not able to access many government funded programs and services available to other immigrants, such as language lessons and career counselling. As a result, many immigrant care workers spend their first years in Canada without significant opportunity to broaden their employment options beyond home care work. These factors "ghettoize" participants in caregiver immigration programs to a limited number of poorly paid and undervalued forms of caregiving labour (11).

Despite both the skill required to perform caregiving labour and the post-secondary credentials held by immigrant care workers, it is clear that immigrants who enter Canada via the Home Child Care Provider and Home Support Worker Pilot Programs experience a process of deskilling, wherein their education, experience, and skills are devalued, and they are limited to low paid and low status home caregiving occupations. Another way in which the labour of immigrant home care workers is constructed as less legitimate than other forms of labour is the conceptualization of immigrant labour as a "sacrifice".

On February 10, 2023, the Canadian government announced via a press release that they would halve the amount of work experience required for immigrants who entered through caregiver immigration programs to complete before applying for permanent resident status. This decrease to the amount of work experience required for caregivers to obtain permanent residency is a positive change that will hopefully decrease the amount of time caregivers spend as temporary foreign workers, however, the language used in this document reflects the assumption

that caregiving labour necessarily requires personal sacrifices beyond the normal expectations of a job. The press release opens by stating: “For decades, caregivers from abroad have played an invaluable role in supporting families in Canada. In recognizing their immense sacrifices, Canada has offered pathways to permanent residence in return.” The theme of recognizing immigrant caregivers’ *sacrifice* is also present in the quotes included in the press release from Liberal MPs Salma Zahid and Rechie Valdez, who announced the policy change. Zahid describes immigrant caregivers as “indispensable in assisting Canadian families” and describes the decreased work experience requirement as a recognition of the sacrifices they make. Valdez states “Reducing work experience and creating reserved pathways to permanent residence are just a couple of ways we can show our appreciation for the sacrifices [...] of caregivers”.

Certainly, immigrant caregivers are often forced to make immense sacrifices in order to seek employment and permanent residency in Canada. Until recently, Canada’s caregiver immigration programs have imposed a two-year period of family separation. Time spent away from one’s family cannot be regained, and this period of enforced family separation certainly constitutes a major sacrifice for immigrant care workers. Even under the current Home Child Care Provider and Home Support Worker Pilot Programs, which allow caregivers’ spouses and children to accompany them to Canada, caregivers must still leave extended family members, friends, and other loved ones behind in their home countries. Caregivers also sacrifice time spent with their family members while waiting for applications to be processed. Further, as discussed earlier in this chapter, many immigrant care workers also sacrifice professional certifications and careers, as their occupational mobility is limited in Canada. Immigrant care workers are also too often expected to sacrifice their dignity and safety in abusive work environments.

The recent press release emphasizes immigrant caregivers' "sacrifice" as a reason for which they should be granted permanent residency. The conceptualization of sacrifice as a precondition for immigrant caregivers to gain recognition as permanent residents serves to justify the exploitation caused by the structure of the caregiver immigration streams and bolsters harmful narratives about care work, as described in Suzanne Day's market model of care. According to Day (2013), the market model of care relies on a "disconnected logic". Within the market model, care is conceptualized as a series of measurable tasks that can be contracted out in the market. However, at the same time, the exploitative nature of many poorly paid and precarious caring occupations relies on the idea that care should be performed out of "the selfless altruism of family-like relationships" (27). As a result, the exploitative working conditions, poor wages, and precarious nature of many forms of undervalued care work (including the work of temporary immigrant care workers) is obscured, as their labour is constructed as a form of "self-sacrifice" (27). Emotional pressure and narratives about altruism and family-like relationships can have a significant impact on the occupational mobility of immigrant caregivers, even after they have completed the required period of work as an in-home caregiver. According to Banerjee et al. (2018), several of the in-home caregivers they interviewed reported that their employers applied guilt and pressure to their employees to keep them from searching for higher paid employment (929). Some caregivers reported that they remained in low-waged, low-status home care positions because they felt "a sense of indebtedness" to their employers, or worried that the care recipient would not receive care if they left (930). Within the market model of care, care workers are expected to accept exploitation in their work and are often coerced into performing unpaid labour outside of the tasks described in their contract. This demonstrates both the limitations of the conceptualization of care as a series of measurable discrete tasks and the ways

in which pressure to fulfil "the altruistic care ideal" compels workers into exploitative working conditions reliant upon their sacrifice (Day 2013, 27). The market model relies on notions of care as an altruistic act rather than a form of work requiring the application of learned skills to justify the low-waged and low-status nature of care work.

The repeated reference to immigrant caregivers' "sacrifice" also reflects gendered assumptions. Some feminists have critiqued the assumption that women should be willing to readily engage in "self-sacrifice", arguing that the association of sacrifice with "feminine virtuousness" demands women's subservience (Hoagland 1997, 196). The demand for exceptional sacrifices from migrant caregivers (the significant majority of whom are women) therefore, both reflects and reinforces the notion that women are naturally altruistic and self-sacrificing, and that women's caregiving labour should be freely available as a resource to be expropriated by others.

The repeated use of the term "sacrifice" in the Canadian government's press release regarding the decrease in work hours required for immigrant care workers to become eligible for permanent residency indicates that the Canadian government is aware of the hardships faced by immigrant caregivers, but still maintains the systems that cause these challenges. Of course, many forms of labour require workers to make some sacrifices. Workers who choose to work in occupations that require them to travel away from home may experience some periodic separation from their family members, usually in exchange for higher wages. However, as outlined in this chapter, immigrant care workers are often forced to sacrifice their safety, dignity, professional experience, and well-being due to the structural conditions of Canada's caregiver immigration streams. Many of the sacrifices made by immigrant care workers could be

eliminated through the implementation of government policies aimed at transforming, rather than merely reforming, Canada's immigration streams for caregivers.

Theme 3: Care as undeserving of adequate compensation

One major contributing factor to the marginalization of immigrant care workers in Canada is the continued prevalence of extremely low wages for home care work. Guidelines about wages to be paid to home support workers and home child care providers are notably absent from much of the information available to both prospective immigrant caregivers and their employers. It appears that employers are expected to pay at least the minimum wage guaranteed by provincial employment standards laws, and that wages are privately determined by employers and codified in contracts between immigrant care workers and their employers. Studies on the former LCP showed that employers often exploited migrant caregivers by demanding that care workers perform unpaid labour outside the hours of a regular employment contract (Bourgeault et al. 2009, 87). While the current Home Child Care Provider and Home Support Worker Pilot Programs do not require caregivers to live with their employers, low wages act as a barrier to obtaining market rental housing (as will be discussed later in this chapter), and it is not clear that the issue of exploitation through demands for unpaid work has been adequately addressed. An article from the Congress of Progressive Filipino Canadians from 2020 — written well after the end of the program's live-in requirement — states that violations of work contracts and demands that caregivers work unreasonably long hours remain prevalent along with other forms of racism and abuse, which many caregivers endure due to fears of deportation or losing their path to permanent residency. Research involving interviews with caregivers suggests that violations of both provincial employment standards and of employment contracts are likely common, but often go unreported due to caregivers' concerns about their precarious immigration

status as temporary foreign workers (Banerjee, Kelly, and Tungohan 2017, 7). Unfortunately, even when employers meet the bare minimum requirements laid out by provincial employment standards, very low wages are standard for immigrant home care workers.

Median wages for all occupations listed in the National Occupational Classification (NOC) database are available through the Government of Canada's Job Bank website. As of November 16, 2022, the median wage for home child care providers across Canada was $17.00/hour. Wages vary from region to region, as minimum wage is determined provincially, but fall between $13.00/hour at the lowest, and $23.12/hour at the highest ("Wages for home child care providers" 2023). Wages for home support workers are very slightly higher, but fall within a similar range, with a median wage of $18.00/hour across Canada, with wages distributed between $14.00/hour at the lowest and $25.00/hour at the highest ("Wages for home support workers, caregivers and related occupations" 2023). At the time of writing, British Columbia's minimum wage is $15.65/hour. In the region classified as "Vancouver Island and the Coast", the median wage for a home child care provider is only $16.00/hour — only 35 cents higher than the provincial minimum wage.[6] While the median wage for home support workers on Vancouver Island and the Coast is higher than that of home child care providers — at $21.09/hour — it still falls below the 2022 living wage calculated by the organization Living Wages for Families BC. Living Wages for Families BC determines the living wage by calculating the minimum hourly wage required for two adults working full-time with two children to earn in order to pay for basic expenses. The living wage calculation takes into account the cost of rent, food, transportation, and child care within a region, and accounts for available tax credits. The living wage only includes basic expenses, and does not represent the

[6] As of June 1, 2023, British Columbia's minimum wage was raised to $16.75/hour. The median wage for a home child care provider listed on the Job Bank website has subsequently been raised to $16.75/hour.

wage required for people to save for their futures or repay debt. According to Living Wages for Families BC, the 2022 living wage in the Greater Victoria Area is $24.29/hour ("Living Wages in BC and Canada" 2022). Many immigrant caregivers may be the sole income-earner for their families upon their settlement in Canada and may also be responsible for sending remittances to family members in their country of origin. Thus, their low wages may be stretched even further than the living wage calculation considers. It is clear from the data outlined above that immigrants working in Canada as home child care providers or home support workers receive low wages that are often not high enough to meet their basic needs or those of their families.

The pervasiveness of low wages for home care workers is acknowledged by IRCC but is not meaningfully addressed. The low wages typically received by caregivers are mentioned in the guidelines used by IRCC officers in determining an applicant's admissibility to the program. Section A39 of IRCC's admissibility guidelines for the Home Child Care Provider and Home Support Worker Pilot Programs, "Inadmissibility for financial reasons" states that while settlement funds are not a required condition for admission to the programs, caregivers' financial ability to provide for themselves and any accompanying family members must be assessed before they are approved for either a work permit or for permanent residency. Caregivers and/or their family members may be denied work permits or permanent resident status if they cannot demonstrate that they are capable of financially providing for themselves and any accompanying family members. The stated intention of the guidelines on inadmissibility for financial reasons is to "prevent the abuse of Canada's social services systems" by denying entry to migrants who may otherwise require social assistance in Canada ("Home Child Care Provider and Home Support Worker Pilot: Admissibility" 2022, para. 4). The guidelines encourage IRCC officers to

determine financial admissibility "with the understanding that the caregiver is often a low-wage position" (para. 2).

Although IRCC officers are advised to only reject an applicant on the basis of financial inadmissibility if they have "very serious concerns" about an applicant's inability to support themselves or their family through means other than social assistance, the very fact that migrant caregivers may be denied permanent residency for themselves or their family members as a result of the low wages they are paid for their labour highlights a major issue with the very premise of the Home Child Care Provider and Home Support Care Worker Pilot Programs. Immigrant care workers are recruited to Canada specifically because the work they perform is in-demand, and desperately needed. They are expected to be self-reliant and refrain from "burdening" Canada's social services. Their spouses and children may accompany them to Canada, but only if they are able to ensure that they will be able to financially support them. Caregivers are required to demonstrate financial security in order to remain in Canada, all while receiving extremely low wages, often well below the living wage of the area in which they work.

Under the Home Child Care Provider and Home Support Worker Pilot Programs, caregivers are no longer required to live in the homes of their employers. However, in the guidelines on financial admissibility, IRCC officers are encouraged to take into account an applicant's living arrangements, noting that: "[if] the applicant will be living in the employer's home or with family or friends, this may allow them more financial flexibility to support themselves and their accompanying dependants" ("Home Child Care Provider and Home Support Worker Pilot: Admissibility" 2022, para. 6). Given the low wages paid to home caregivers, the ability to live outside of one's employer's home, though it is likely a desirable option, may be financially out of reach. Across Canada, rent costs have been on the rise, and in

many Canadian cities, the rental market is extremely competitive. Between 2021 and 2022, British Columbia saw the country's highest increase in average monthly rental costs, with an increase of almost 25% (Bruce et al. 2022). As a result, poorly compensated care workers may be unable to afford to rent an apartment, suite, or even a room in a shared house while also upholding other financial obligations, such as sending remittances back home or supporting family members. Therefore, even though the Home Child Care Provider and Home Support Worker Pilot Programs no longer require caregivers to live in the home of their employer, like the LCP did, low wages and rising rent prices may mean that many caregivers still lack any meaningful choice or autonomy in their living arrangements.

Low wages may also impede immigrant care workers' ability to leave abusive employment situations. Although the Home Child Care Provider and Home Support Worker Pilot Programs allow care workers to change employers, IRCC does not provide immigrant care workers with assistance in finding a new employer within their occupation (either in-home child care or in-home support work). In order to change employers, therefore, immigrant care workers must find another employer in need of a home child care provider or home support worker for themselves, either staying with the abusive employer while conducting their job hunt, or facing a period of unemployment before securing a new job. Workers who are living on extremely low wages are unlikely to have significant savings to support themselves and their family members through a period of unemployment. Leaving an abusive employer may also require a care worker to find a new place to live, if they are living in the employer's home. All this means that poorly compensated care workers may face insurmountable financial hurdles if they change employers. In IRCC's 2020 Annual Report to Parliament on Immigration, many of the changes made to the Home Child Care Provider and Home Support Worker Pilot Programs attributed to their

"Gender-based Plus" analysis — including the replacement of employer-specific work permits with occupation-specific work permits — have the stated goal of reducing immigrant workers' exposure to abuse and exploitation. IRCC's claim that these policy changes are the outcome of GBA+ analysis is unclear, and the details of their analysis are not explained. Regardless, even if all these changes to the Home Child Care Provider and Home Support Worker program are implemented, material changes in the lives of workers will be minimal without increased wages. If workers lack the financial stability required to change employers, IRCC's stated goal of reducing the abuse and exploitation of immigrant care workers will not be realized.

Home child care providers and home support workers are paid abysmally low wages, even as they perform essential labour. Applicants to the Home Child Care Provider and Home Support Worker Pilot Programs may be denied access to work permits or permanent residency status as a result of financial instability resulting from their low wages. Immigrant caregivers are expected to accept meager wages, but their access to secure work and permanent residency is made more precarious by the meagerness of their compensation. Caregivers are no longer required to live in their employer's homes but may be paid so little that they are unable to afford any alternative living arrangements. The persistence of extremely low wages for home caregiving labour perpetuates the marginalization of immigrant caregivers and reinforces the low-status nature of care work and the labour of racialized women.

Theme 4: Care as private

The Home Child Care Provider and Home Support Worker Pilot Programs are specifically designed to facilitate the immigration of *privately employed* care workers into Canada. The Government of Canada is not party to the contracts established between immigrant care workers and their private employers. Caregivers are privately employed by care recipients

or their family members to work within their homes. The Home Child Care Provider and Home Support Worker Pilot Programs do not contribute to the development of publicly funded care programs for elders, children, and people with disabilities. As noted by the Congress of Progressive Filipino Canadians (2020), the Home Child Care Provider and Home Support Worker Pilot Programs (along with their predecessors: the Caregiver Program and the LCP) are inaccessible for many Canadians who require care. These programs not only highlight the yawning wealth gap between the Global North and the Global South, but also highlight wealth inequality within Canada, as the type of private care offered through these programs is only accessible to Canadians belonging to "privileged classes" who have enough wealth to hire a private caregiver (Hanley, Larios, and Koo 2017, 122).

The private nature of the Home Child Care Provider and Home Support Worker Pilot Programs highlights the lack of federal public programs designed to provide care for all Canadians in need, regardless of income level. This highlights the relevance of one of the questions posed by McPhail (2003) in her feminist policy analysis framework: "Where are the policy silences? [...] What policy is *not* being proposed, discussed, and implemented?" (58). In the case of the Home Child Care Provider and Home Support Worker Pilot Programs and their predecessors, although some changes have been made to the program's requirements, the framework is essentially the same: temporary foreign workers are recruited by private employers or agencies to perform caregiving labour within the homes of Canadians with high enough incomes to afford to purchase caring services privately. While the Canadian federal government has expressed its goal to reduce child care fees across the country to $10/day by 2026 ("Toward $10-a-Day: Early Learning and Child Care", 2023), similar movements towards federal universal and publicly funded care for seniors and people with disabilities is not evident. While the

possibility of a federal program for subsidized child care is certainly positive, publications from the Government of Canada discussing the plan do not offer substantive information about rates of pay, benefits, and working conditions for early childhood educators and other child care professionals. The promotion of the Home Child Care Provider and Home Support Worker Pilot Programs as a solution to Canada's crisis relies upon the notion that care services are most appropriately provided through private, market-based contracts. As discussed earlier in this chapter, this concept is central to the market model of care, as conceptualized by Suzanne Day (2013). Within the market model of care, "finances take centre stage in care decisions"; those who do not have access to sufficient funds to purchase private care services may be left with few options (26). Charie Siddayao, writing for the Philippine Women Centre of Ontario, describes the caregiver streams of the Temporary Foreign Worker Program as "short-term band-aid solutions" that contribute to a "profit-driven healthcare model" in Canada (2021, para. 4). Siddayao (2021) suggests that ending the Home Child Care Provider and Home Support Worker Pilot Programs would be a step towards establishing genuinely universal care programs in Canada.

In addition to facilitating only private employment performed on the basis of a contract between the care worker and their employer, the Home Child Care Provider and Home Support Worker Pilot Programs only allow for caregivers to work within the private homes of the care recipient. These factors contribute to the vulnerability of immigrant home care workers. As discussed earlier in this chapter, under the Home Child Care Provider and Home Support Worker Pilot Program, care workers perform care work based on private contracts negotiated between themselves and their employers. The Canadian government is not party to these contracts, and employees are responsible to know their rights and report violations. As noted by Hanley, Larios,

and Koo (2017), the conditions of the caregiver stream of the Temporary Foreign Worker Program place immigrant care workers in precarious positions in which they are not empowered to raise concerns about their rights in the workplace, often because of fears of deportation, or as a result of isolation and a lack of resources and support to recognize and report abuse. Although contracts are required to comply with federal and provincial labour standards, the nature of private employment within an employer's home combined with the significant power dynamic inherent to the contracts negotiated between vulnerable temporary foreign workers and their class-privileged Canadian employers create conditions that increase the likelihood of unreported abuse and exploitation. One feature of the type of private, in-home employment required by the Home Child Care Provider and Home Support Worker Pilot Programs is that immigrant home care workers are typically the sole employee in their workplace (Larios, Hanley, and Koo 2017, 129). As a result, oversight of an employer's treatment of their employee is minimal, the possibility of labour organization and unionization is non-existent, and precariously employed care workers have little recourse against labour standards violations.

The Home Child Care Provider and Home Support Worker Pilot Programs promote a specific type of private care that is accessible only to wealthy Canadians. It also creates the conditions for workplaces with extremely minimal oversight, in which abuse and exploitation may go unnoticed or unreported. Policies that promote the private employment of temporary foreign workers do not increase the accessibility of care for most Canadians. Care is a matter of public health: it is needed by Canadians of all income levels and is deserving of robust public funding. Private solutions that rely upon the exploited labour of temporary foreign workers and are only accessible to wealthy Canadians are unsustainable and inadequate. The care crisis

cannot be solved through market-based solutions that fit within the structure of neoliberalism and rely upon the often coerced and exploited labour of poorly paid care workers (Day 2013, 27).

Conclusion

This chapter discusses the Home Child Care Provider and Home Support Worker Pilot Programs, which are the latest iteration of Canadian immigration policy designed to facilitate and regulate the import of immigrant care workers to be privately employed within the homes of Canadians seeking in-home care. Similar to the previous chapter, I used feminist critical discourse analysis and feminist policy analysis to uncover the assumptions about care embedded in these programs - specifically the gendered assumptions. As shown, despite appearing as two very different sets of policies that provide and structure in-home care in Canada, both EI benefits for caregivers and immigration programs that facilitate the immigration of private, in-home caregivers are underpinned by a common set of assumptions about care. As demonstrated in these chapters, these similarities demonstrate that both sets of Canadian public policy regarding care rely on a shared set of gendered narratives about care and care providers. In many ways, the structure of these programs serves to reinforce neoliberalism within Canada, and globally.

My research suggests that the import of caregivers from the Global South for private employment in the homes of upper-middle- and upper-class Canadians through the Home Child Care Provider and Home Support Worker Pilot Programs neither solves the care crisis for Canadians in need, nor does it ensure the safety, dignity, and equity of immigrant care workers, the vast majority of whom are racialized women. Canada's immigration streams for caregivers allow for the exploitation, marginalization, and abuse of immigrant care workers, who are often forced to wait for years to receive their work permit and permanent residency, receive extremely low wages, and become trapped in low-wage, low-status care work regardless of their education

and experience. Despite the changes made to Canada's caregiver immigration streams from the start of the LCP in 1992 to the February 2023 announcement regarding the decrease in required work experience for caregivers entering through the Home Child Care Provider and Home Support Worker Pilots, many structural factors that facilitate the exploitation of immigrant care workers have remained consistent. Not unlike other workers waiting for PR, but perhaps particularly problematic given the low wages of care workers, IRCC's backlogs and slow processing times force immigrant care workers to wait in limbo for long, indeterminate periods of time to obtain either their work permit, or to receive permanent resident status. The Home Child Care Provider and Home Support Worker Pilot Programs do not provide employers with any guidance or regulation regarding wages to be paid to care workers, allowing employers to offer extremely low wages, often barely above the provincial minimum wage, regardless of the education or experience of the care worker. As a result of the extremely low wages they are paid, care workers may be unable to financially support their family members, who may be denied entry to Canada based on financial inadmissibility. Care workers may become trapped in abusive or exploitative employment situations because they lack the financial security required to quit and search out a new employer. Care workers often lack occupational mobility and are restricted to a small number of ghettoized low-status and low-waged occupations due to barriers to the recognition of education and certification obtained in their country of origin. Immigrant care workers are expected to accept immense sacrifices as necessary preconditions to gaining recognition as a permanent resident. The Canadian state could minimize the sacrifices required from immigrant care workers by granting them permanent resident status upon arrival (as is granted to immigrants entering through the federal skilled worker streams, including those in the male-dominated resource extraction sector), by requiring employers to pay caregivers a living

wage that allows caregivers to provide for their families and grants them the freedom to leave exploitative employers without facing insurmountable financial consequences, and by simplifying the process by which foreign credentials become recognized in Canada. Currently, the Home Child Care Provider and Home Support Worker Pilot Programs compel participants into precarious temporary employment, and both reflect and reinforce social narratives regarding the low-status and low-waged nature of caregiving labour.

Conclusion: Care Work – Where to Go From Here?

Care work is incredibly important work in any society, and the global COVID-19 pandemic drew much needed attention to staffing issues and other challenges in both elder and child care in Canada and elsewhere. It is no surprise, then, that many scholars and policy makers would agree that Canada is facing a crisis of care. However, how this crisis might be addressed is unclear, and subject to much debate. In this thesis, I sought to identify some of the assumptions about care and social narratives around care as one way to begin expanding the debate regarding the care crisis and possible policy responses. I began with a broad question: what are the assumptions about care shaping the key policies and government initiatives that provide and support private, in-home care in Canada? I was curious about what kinds of social narratives could be influencing policies that structure the provision of care in Canada. More narrowly, I asked: Are there any common or similar assumptions about care underpinning different policies regarding in-home care? If so, what are these assumptions and how do these assumptions, in turn, shape the provision of care?

I answered these questions by focusing on two clusters of policies: EI benefits for unpaid family caregivers, and the Home Child Care Provider and Home Support Worker Pilot Programs (subsets of the Temporary Foreign Worker Program designed to facilitate the immigration of private in-home caregivers to Canada). I took this approach because, despite the rich scholarship on previous caregiver immigration policies, few studies have explored the role of EI policies on unpaid family caregivers, and no studies have examined these policies together. Using feminist critical discourse analysis and feminist policy analysis, I examined both clusters of policies and used inductive coding to establish if any common assumptions were present. My initial findings pointed to common gendered assumptions. I narrowed my codes into themes that appear to

stretch across both policy areas, and then used these themes (deductive coding) to closely examine government website and other documents to test whether these themes were the most dominant in the policies. My research showed that both sets of policies reflected and reinforced an underlying set of gendered assumptions: that care is temporary, that care is a less legitimate and valuable form of labour than other types of work, that care is undeserving of adequate compensation, and that care is a private, rather than public or social, concern.

Chapter one explored federal financial benefits allocated to unpaid family caregivers. My analysis focused on the Employment Insurance Compassionate Care Benefit, the Employment Insurance Family Caregiver Benefit for Children, and the Employment Insurance Family Caregiver Benefit for Adults, together referred to as EI benefits for caregivers. EI benefits for caregivers offer a partial and temporary replacement of wages lost by workers who must temporarily leave the formal labour market to provide care for a family member. Chapter two analyzed policies that regulate the immigration of in-home care workers into Canada through the framework of the Temporary Foreign Worker Program, through to the current Home Child Care Provider and Home Support Worker Pilot Programs, which will remain operational until 2024. The primary foci of my analysis of immigration programs for caregivers are the current Home Child Care Provider and Home Support Worker Pilot Programs.

Overall, building on the work of prominent scholars who focus on policies related to care (Armstrong 2013; Struthers 2013), my research shows that the care crisis in Canada crisis is worsened by the persistence of neoliberal policies that fail to reflect the immense value of care work and the people who perform it. Neoliberal policy responses to the care crisis have relied upon the unwaged and often unsupported labour of family caregivers, and on the low-waged and

low-status caring labour of temporary foreign workers. These neoliberal policies both reflect and reinforce several gendered assumptions about the nature and value of care and care workers.

On the surface, these two sets of policy may appear largely unrelated. They address two different groups of caregivers: unpaid family caregivers and paid immigrant in-home care workers. However, my analysis demonstrates that both sets of policies are underpinned by a similar set of gendered social narratives about care and those who provide it.

First, care is conceptualized as temporary. The conceptualization of care as temporary reflects the assumptions present within the family model of care, as described by Suzanne Day (2013). Within the family model, dependency on others for care is defined as an "abnormal condition", rather than a "universal need" (23). In the case of EI benefits for caregivers, the assumption that care is only a temporary need is reflected in the time limits imposed on the benefits available to caregivers. Further, EI benefits are only intended to partially replace lost income for care provided in response to acute illness or injury, rather than chronic illness. Within a broader policy context, the assumption that family members' caring responsibilities are temporary, rather than ongoing, is reflected in the lack of job-protected leave available for family caregivers.

In the case of the Home Child Care Provider and Home Support Worker Pilot Programs, the theme of care as temporary is reflected primarily in the ways in which workers are treated as temporary, disposable, and exploitable resources. This is most obviously evident in the program's place within the Temporary Foreign Worker Program. Although care workers entering through the Home Child Care Provider and Home Support Worker Pilot Program are promised a pathway to permanent residency after working as an in-home caregiver for one year, extreme delays in IRCC's processing of applications for the program itself and for permanent residency

for workers who have completed the required period of work has resulted in many care workers being forced to wait in limbo for unreasonably long periods of time. While waiting for their application for permanent residency to be processed, which can sometimes take years, many care workers are required to re-apply for temporary employment authorizations, retaining their precarious temporary status much longer than the program's guidelines suggest. The enforced precarity of immigrant home care workers waiting unreasonable periods of time for recognition as permanent residents reflects an unsustainable view of care workers as temporary and disposable. While the depiction of care and care workers as temporary may not appear explicitly gendered on its surface, this assumption is rooted in the notion that requiring care is an abnormal and temporary deviation from a norm of independence and self-reliance; a notion challenged by some feminist scholars (Jaggar 1983; Pateman 1988). Long-term, ongoing caring relationships form the basis of human interdependence within society, which is "necessitated by human biology" (Jaggar 1983, 41). As argued by Chatzidakis et al. (2020), the need for care has been "pathologized" due to the ways in which "autonomy and independence have historically been lionised in the Global North and gendered 'male'" (23). The elevation and normalization of "notions of unfettered male autonomy and independence" pushes care to the margins and affirms social narratives that mark dependency on care as abnormal, deviant, and undesirable (23). By imagining caring relationships to be temporary and treating care providers as a temporary and disposable resource, both sets of Canadian policy under examination in this thesis rely upon implicitly gendered norms of independence and self-reliance.

The second common assumption is the portrayal of care as secondary in importance and legitimacy to other forms of labour: the idea that care work is consistently portrayed as less "real" than other forms of labour. This assumption is expressed through the ways in which care

is understood to be a burden that should be shed as quickly as possible to allow the caregiver to return to the paid labour market. While it is certainly true that periods of unemployment necessitated by caring responsibilities have negative financial effects on many individuals, these policies do not seek to recognize familial care work as equal in importance to formal wage labour. Rather, EI benefits for caregivers grant financial support to caregivers only based on their prior participation in the formal labour market, rather than on the value of their caring labour itself. As articulated in Day's (2013) family model, care is not understood as "productive" labour or awarded social value on its own terms; rather, it is understood as an interruption to a worker's normal participation in the formal labour market (24). Private care provided by families (and not supported by the state) is idealized as the best and most natural form of care, while simultaneously, family caregivers suffer significant financial consequences for engaging in care work outside the formal paid labour market (24). Care, therefore, is not recognized as equal in importance and value to wage labour, despite its significant economic and social value. Familial care, no matter its frequency and intensity, is not itself conceptualized as a legitimate form of labour deserving of financial support from the federal government.

In the case of immigration policy regarding paid in-home immigrant care workers, the assumption that care work is less valuable and legitimate than other forms of work is evident in the classification of in-home care work as low-skilled labour, regardless of the education, experience, and learned skills possessed by workers. In-home child care and support work are both classified within the Canadian government's TEER (training, education, experience, and responsibilities) system as TEER 4, and are excluded from express immigration programs for skilled workers (including workers in the male-dominated resource extraction industry). The skills exercised by in-home care workers — even those with educational certifications and years

of experience in the healthcare industries of their countries of origin — are often assumed to be natural and are conceptualized as an extension of the unpaid caring labour women often provide for their families, which, as noted above, is undervalued and unrecognized as valuable and important labour in its own right. The lack of value afforded to both the emotional labour of care work as well as the daily physical tasks required to ensure the health, comfort, and safety of care recipients reflects the assumptions of the medical model of care, as described by Suzanne Day (2013). Within the medical model, only clinical bodily interventions intended to cure a patient of a biological ailment are elevated as the most valuable, legitimate, and skilled forms of care, whereas the social, in-home care provided by participants in the Home Child Care Provider and Home Support Worker Pilot Programs is undervalued and assumed to require only low levels of skill. Even those care workers with postgraduate degrees and certifications often face barriers to recognition of their credentials and remain in undervalued caring occupations where their skills are often rendered invisible. Care work is also frequently described in government-issued discourse as an altruistic sacrifice. This reflects the assumptions inherent in Suzanne Day's (2013) explanation of the market model of care, in which care work is imagined as something that should be performed not for money like any other job in the formal labour market, but as an act of altruistic self-sacrifice. The market model of care relies on idealized notions of care as "altruistically fulfilling" labour that ought to be performed as a selfless sacrifice to justify low-wages, poor working conditions, and exploitation of care workers (27) As noted by some feminist scholars, women are often expected to engage in self-sacrificial behaviour to serve others (Hoagland 1997, 196). The description of care work as a sacrifice and the expectation that it ought to be performed out of selfless altruism, therefore, reflects and reinforces gendered social narratives about women's labour. The labour of women immigrants working as in-home

caregivers is treated not as the skilled performance of a valuable occupation, but rather, as a natural resource that should be given freely out of altruistic self-sacrifice.

The third assumption is that care work is undeserving of fair compensation commensurate with a living wage. This theme is particularly intertwined with the previous theme outlined above: the assumptions that care work is low-skilled, natural, and that it ought to be performed as a form of self-sacrifice serve to reinforce the belief that care work is only deserving of minimal financial compensation and low wages. Within the context of EI benefits for caregivers, the assumption that caregiving is undeserving of adequate compensation is reflected in multiple ways. EI benefits are only a temporary and marginal replacement of lost income for workers who qualify. For low-income carers, even if they are able to qualify for EI benefits, 55% of their regular income may be inadequate to cover even the most basic expenses. Workers whose caregiving responsibilities cause them to decrease their hours of paid work or leave the formal labour market face both acute and long-term financial consequences, including reduced pensions and retirement savings. As women are more likely than men to decrease their paid work hours in response to family member's intensive care needs, these financial impacts are gendered. The gendered financial impact of family caregiving in Canada highlights the relevance of a question asked by McPhail (2003) in her feminist policy analysis framework: "Are women's unpaid labour and work of caring considered and valued or taken for granted?" (55). As demonstrated both within my analysis of this theme and my analysis of the previous theme, Canadian policy takes informal family care for granted as a free and natural resource, and it is not considered to be a legitimate form of work deserving of adequate financial compensation commensurate with its economic and social value. Another question included in McPhail's (2003) feminist policy analysis framework is also relevant: "Where are the policy silences? [...]

What policy is *not* being proposed, discussed, and implemented?" (58). In the case of family caregivers, the Canadian state has not proposed or implemented a federal program allocating direct payments to caregivers based on their caregiving labour alone. Direct financial compensation for caregiving labour is tied to EI benefits, which are inaccessible for many part-time workers, as well as those who have been absent from the formal labour market. Indirect sources of financial support, like those offered through tax credits, do little to support the lowest-income and most financially vulnerable family caregivers. The limited and marginal financial support offered to family caregivers by the Canadian federal government reflects the assumption that caregiving labour is undeserving of adequate financial compensation.

In the context of the Home Child Care Provider and Home Support Worker Pilot Programs, extremely low wages are the norm. The Canadian median wage for home child care providers is $17.00/hour. The Canadian median wage for home support workers is $18.00/hour. Wages vary across different regions within Canada, but overall, they are notably low, falling below the amount required for a living wage. The extremely low wages received by temporary foreign workers within the caregiving programs are noted by Immigration, Refugees, and Citizenship Canada, but are not meaningfully addressed. Troublingly, officers assessing applications for permanent residency are even able to deny permanent resident status to a caregiver who has completed the required period of in-home care work on the basis of insufficient finances, in an effort to prevent them from "abus[ing]" social programs and services in Canada ("Home Child Care Provider and Home Support Worker Pilot: Assessing the application against selection criteria." " 2022, para. 4) The low-waged nature of in-home care work also significantly hinders the autonomy of immigrant care workers. Low wages hamper the ability of in-home caregivers to obtain market rental housing and may restrict them to living

within the home of their employer. Low wages may also act as a barrier to care workers attempting to leave abusive or exploitative employers. Due to their status as temporary foreign workers, participants in the Home Child Care Provider and Home Support Worker Program are excluded from the job search support available to immigrants entering Canada through other streams. Workers who decide to leave an exploitative or abusive employer must therefore find a new employer for themselves. Due to the structure of the program, they are required to remain in either in-home child care or in-home support work, and cannot take a job outside of these occupations. Care workers who are receiving extremely low wages are unlikely to have significant savings, and may be unable to support themselves and their families through a period of unemployment while searching for a new employer. The low wages received by care workers prevent them from gaining the financial security and stability required to leave exploitative and abusive situations. The extremely low-waged nature of in-home care work, therefore, hinder the success of some of the reforms made to the caregiver stream of the temporary foreign worker program, including the removal of the requirement for care workers to live in the homes of their employers. The low wages paid to in-home immigrant care workers create the conditions for precarity and exploitation.

The final theme is the portrayal of care as a private matter, rather than a social issue. The two sets of policy reflect this theme in different, but interconnected ways. In the context of the policies that allocate federal funding to family caregivers, the assumption that care is a private issue supports the downloading of care to unpaid and unsupported family members, the majority of whom are women. In her description of the family model of care, Day (2013) argues that policies that define care as a fundamentally private need best provided by unpaid family members within the home reinforce the myth that society can be split into a private sphere

(associated with the reproductive labour performed primarily by women throughout history) and the public sphere (associated with political activity from which women were historically excluded). The belief that care rightfully belongs within the private sphere both reinforces the notion that it is women's work and obscures the ways in which political activity and public policy significantly influence the labour of family caregivers, minimizing the importance of public support for family caregivers. The assumption that care is a private issue is also reflected and reinforced through the requirement that caregivers receiving EI benefits must be family members of (or be considered like family) to the care recipient. The narrative that care is private is further reflected in the Government of Canada's recommendations regarding financial management for caregivers. Caregivers seeking financial support from the Canadian federal government are directed to websites that encourage them to make a budget and stop overspending on luxury goods like designer shoes. Not only are these recommendations condescending, but they also reinforce the idea that poverty or financial hardship is a personal failing, brought about not because of structural inequalities and insufficient social programming, but as a result of individual bad choices and poor self control. In this sense, not only is care conceptualized as a private concern, but so are the negative financial consequences faced by those who provide it.

In the case of the Home Child Care Provider and Home Support Worker Pilot Programs, the social narrative that care is a private matter, rather than a matter of public health is reflected in the program's focus on the recruitment and immigration of privately employed in-home care workers, rather than care workers to be employed within the public healthcare system. Privately employed in-home caregivers are only accessible to high-income Canadians. This reflects the market model of care, in which care is organized on the basis of financial profit and caring

practices are narrowed to a set of quantifiable tasks that can be conducted on the basis of a market contract (Day 2013, 26-27). Some immigrant rights advocates, including Charie Siddayao of the Philippine Women Centre of Ontario, argue that programs aimed at importing care workers from the Global South into private home care occupations in Canada are only "short-term band-aid solutions", contributing to the entrenchment of a "profit-driven healthcare model" in Canada and deterring the development of public policies supporting truly universal care (2021, para. 4). Further, the specific conditions of the private in-home care work performed by temporary foreign workers — wherein workers are usually the sole employee in a workplace, unionization is non-existent, and oversight of an employer's treatment is minimal or absent — allow for abuse and exploitation to occur and remain unreported. In short, care is conceptualized as a private need, rather than a widespread public health concern.

The privatization of care within these two sets of policies reflects two ways in which care has been redistributed in the neoliberal era of welfare state retrenchment. Both unpaid family caregivers and low-waged and low-status temporary foreign workers have taken on caring labour that is excluded from the welfare state. The marginal and limited federal financial support offered to informal family caregivers reflects the Canadian state's assumption that unpaid family members (the majority of whom are women) will simply fill in the gaps left by welfare state retrenchment, without adequate concern for the significant psychological and physical health challenges experienced by informal caregivers because of their intensive and unsupported caregiving responsibilities. The Home Child Care Provider and Home Support Worker Pilot Programs rely on underpaid, overqualified, and often exploited immigrant caregivers, who are denied the rights, services, and security that come with permanent residency until they have performed the self-sacrifice of low-waged and undervalued in-home care work for privileged,

high-income Canadians. Both groups of care workers are treated as private band-aid solutions to Canada's care crisis: the Canadian state relies on their labour to make up for the holes in Canada's universal healthcare system.

In my analysis, I found that the assumptions underpinning both sets of policies were consistently reflective of gendered social narratives about care, who should provide it, and how it should be provided. Class assumptions were also evident in both sets of policies. Both unpaid family caregivers and paid immigrant care workers are likely to experience financial hardship due to poorly compensated nature of their work. While unpaid family caregivers are offered patronizing advice about budgeting, immigrant care workers may be denied permanent residency if they are determined to be financially inadmissible (a risk that is heightened by the low wages characteristic to the program). However, not all themes were consistent between both sets of policy. Some outcomes of policies designed to facilitate the immigration of private, in-home caregivers to Canada are also reflective of racialized assumptions. For example, scholars note the relevance of racist stereotyping and discrimination from employers. As discussed briefly in chapter two, even after completing the required period of employment as a live-in caregiver, many immigrant care workers remain in the low-waged in-home care sector, even if they are qualified for higher paid work. Banerjee, Kelly, and Tungohan (2017) point to "racialization and discrimination based on employers' stereotypes" as partly responsible for the "ghetttoiz[ation]" of these workers (11). Armstrong (2013) also points out that racialized stereotypes play a role in the social construction of skills, and notes that employers may tend to view racialized workers as better suited for "low-skilled" forms of labour. Further, the Congress of Progressive Filippino Canadians (2020) reports that racism is one of the driving factors behind the violence and abuse experienced by some immigrant care workers. As such, race clearly plays an important role in

determining the experiences of participants in the Home Child Care Provider and Home Support Worker Pilot Program. However, I did not find these issues within the EI benefits for caregivers studied in chapter one. The information I accessed regarding the demographics of caregivers in Canada through Statistics Canada did not include a breakdown of the race or ethnicity of survey respondents. However, it did highlight the gendered disparity of unpaid caregiving in Canada. As a result, this thesis largely focused on the consistent gendered assumptions I identified within both sets of policies, noting also the similar relevance of class. The impact of racialized assumptions was somewhat of an outlier, only really showing up within the policies discussed in chapter two. This reflects a limitation of this study: without data regarding the race and ethnicity of unpaid family caregivers, a direct comparison of racialized assumptions between these two sets of policies is not possible.

One further limitation of this study is that it does not provide a systematic comparison of the process of obtaining permanent residency by immigrants entering through different programs and streams. Due to my focus on the Home Child Care Provider and Home Support Worker Pilot Programs, I noted the challenges faced by participants in these programs in accessing permanent residency. These challenges appear to be largely attributed to issues of policy implementation. As noted in McPhail's (2003) feminist policy analysis framework, the effectiveness of policies may be hampered by a lack of "provisions for funding, enforcement, and evaluation" (57). Indeed, the delays experienced by participants in the Home Child Care Provider and Home Support Worker Pilot Programs are considered notable and particularly egregious by immigration lawyers and consultants (Keung 2021). However, without a systematic comparison to the delays and backlogs experienced by immigrants entering through other streams, I cannot claim with certainty that these issues are unique to this program. While such a systematic study

is beyond the scope of this thesis, a further exploration of these issues of policy implementation may be a worthwhile topic for further research in the field.

The Home Child Care Provider and Home Support Worker Pilot Programs have undergone a number of changes, some of which have occurred relatively recently. Most notably, the program's requirement for Canadian work experience within in-home care provision occupations was halved in February 2023. The long-term implications of this change have yet to be reported, and it remains to be seen if this reform will have a significant impact on the speed with which applications for permanent residency are processed. Further, the potential impact of Canadian federal government's recent pledge to decrease nationwide child care fees to $10/day by 2026 on the demand for migrant child care providers also remains to be seen. The Home Child Care Provider and Home Support Worker Pilot Programs are set to conclude in June 2024, and further research within this field depends on the Canadian federal government's decision to renew the pilot programs, develop a new, more permanent program, or implement other significant changes to Canada's Temporary Foreign Worker Program.

In Canada, the organization of care remains largely fragmented and inadequately supported by public programs. In the absence of well-funded social programs designed to address the growing disparity between the number of Canadians who require intensive care and those who are able to provide it, the Canadian government has relied upon the labour of two groups of care workers, the majority of whom are women: unpaid family caregivers and temporary foreign workers. While the experiences of these two groups of care workers is certainly not identical, this analysis has demonstrated that the sets of Canadian federal policy that regulate both groups' labour share a similar underlying set of themes that result in the devaluation of care and those who provide it. In both groups of caregivers, the strain of

performing challenging, undervalued, and undercompensated labour takes a toll on workers' well-being: unpaid family caregivers report a range of psychological and physical health issues as a result of their unsupported caregiving responsibilities, and abuse and exploitation of temporary foreign workers employed as in-home caregivers are well documented. The reliance on overburdened, underpaid, precariously employed, and exploited women to fill the gaps in Canada's fractured public programs is unsustainable, and risks the well-being of both care workers and care recipients.

The distribution of care to unpaid family members and privately employed immigrant care workers reflects three of Suzanne Day's (2013) care models. The federal government's reliance on unpaid family members to provide care without sufficient financial support reflects the family model, in which care is assumed to be fundamentally "women's work", best provided by the recipient's family members within the home (22). The structure of the caregiver streams of the Temporary Foreign Worker Program reflect both the medical model and the market model. The medical model is relevant in the way in which it elevates clinical, biomedical intervention aimed at curing a patient over the social care and daily tasks performed by in-home care workers. The market model reflects a number of the issues with the Home Child Care Provider and Home Support Worker Pilot Programs. Within the market model, care is conceptualized as a set of tasks performed within the context of a market-based contract. However, the market model also relies upon a notion of care as "being inherently altruistically fulfilling through the exploited labour of poorly remunerated and low-status care workers, who experience numerous occupational pressures and hazards as a result of neoliberal care restructuring" (Day 2013, 27). Care workers are expected to perform their work out of altruistic self-sacrifice, and accept extremely low wages, workplace hazards, and exploitation.

My research reveals an underlying set of shared assumptions — rooted in gendered social narratives and beliefs — that are present within two sets of Canadian policy: policies that allocate federal funding to unpaid family caregivers, namely through EI benefits, and policies that facilitate the immigration of temporary foreign workers to be employed as private, in-home caregivers, namely the Home Child Care Provider and Home Support Worker Pilot Programs. The themes revealed by my analysis illustrate the ways in which Canadian federal policy relies on the undervalued, undercompensated, and often exploited labour of women to provide the care that remains excluded from publicly funded programs. Canada's care crisis cannot be solved by the continual reliance on "short-term band-aid solutions" (Siddayao 2021, para. 4). Any genuine solution to the care crisis will require significant public funding and cooperation between federal and provincial governments to ensure that children, elderly individuals, and people with health challenges have access to affordable, equitable, and high-quality care, and that care workers are appropriately compensated and guaranteed safe working conditions. Canadians cannot afford to continue treating care as an afterthought.

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