Contracting Out Hospital Support Jobs: The Effects of Poverty Wages, Excessive Workload, and Job Insecurity on Work and Family Life

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What is This?
Contracting Out Hospital Support Jobs: The Effects of Poverty Wages, Excessive Workload, and Job Insecurity on Work and Family Life

Daniyal Zuberi

Abstract
Based on in-depth interviews with 70 hospital support workers in Vancouver, Canada, this article describes how the contracting out of their jobs to multinational corporations has had deleterious consequences for these workers, their families, and the health care system. Privatization and outsourcing resulted in a steep initial wage reduction for hospital support staff, decreasing by up to 50% from approximately $18 to $20 per hour to between $9 and $12 per hour—with much weaker job benefits. Despite recent wage increases as a result of Hospital Employees’ Union–led contract negotiations, workers still earn lower hourly wages than they did before contracting out and report challenges making ends meet. The concluding discussion presents the implications of these findings for the sociology of work and health and proposes some policy reforms for mitigating the negative consequences of privatization. The article also describes the beginning of a living-wage movement in Vancouver that has emerged in part as a result of this decision to outsource these hospital support jobs.

Keywords
contracting out, neoliberalism, immigrant workers, working poor, health care

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Working Poor and Working Hard: Research on Low-Wage Service Workers

I find working [in] the hospital, you’re susceptible to picking up things because you go into all the rooms for my job. Then it puts me at potential [risk for catching] like colds. There’s not a lot of sick time in our company, and . . . to me that’s a concern working in the health care environment. . . . If you miss a day of work, you miss out on vital money, because you don’t make a lot of money. And one paycheck is my rent. . . . That makes it very stressful. (Barbara Carlisle, hospital dietary aide, mother of two children)\(^1\)

Barbara Carlisle’s situation exemplifies some of the multiple stresses faced by outsourced hospital support workers, whose limited resources and challenging work environment result in precarious outcomes. At a broader level, the rapid expansion of contracting out of service work in health care is reshaping economies globally, expanding the number of low-wage jobs in the service sector.

The Trend Toward Neoliberal Policy and Poverty

The experiences of outsourced hospital workers in Vancouver represents one important lens through which to better understand the challenges facing low-skilled workers in the service sector, particularly, the neoliberal version of franchise capitalism that increasingly dominates the economies of advanced industrialized countries and postindustrial cities. The Hospital Support Workers Study builds on and contributes to several sociological literatures, including debates about growing urban poverty and inequality in Canada, the working poor, the experiences of recently arrived ethnic minority immigrants, and the social determinants of health. The broader substantive context is growing poverty levels in Canada, generally, and specifically among ethnic minority immigrants in Canadian urban centers.

Although much of the sociological research on poverty in advanced industrial nations in the past has focused on public assistance recipients, this research is based on the growing recognition that many households with income below the poverty line include one or more people with formal employment, often in the service sector (see Newman, 1999, 2006). The challenges facing the working poor are beginning to gain greater recognition in both the public and academic realms.

The Hospital Support Workers Study explores the conditions of work in an understudied but critically important part of the service sector. It also examines the role of government employment policies and reforms for constructing social stratification in a postindustrial city and economy. As provincial governments in Canada (including British Columbia) follow the example of the United States in restricting access to public assistance benefits and in applying punitive sanctions to push more poor people
off public assistance and into formal employment (Hays, 2003), it is increasingly important to understand the dynamics of the low-wage labor market.

Research on Working Poverty

There is growing popular attention and research on the conditions of low-wage service-sector employment. For example, Barbara Ehrenreich’s (2001) Nickel and Dimed: On (Not) Getting By in America focuses on private-sector jobs at Wal-Mart, waitressing at a diner, and housecleaning with Merry Maids. Most of the sociological research on the working poor has focused on particular occupational sectors, including fast food (Newman, 1999; Reiter, 1993; Leidner, 1993), garment factories (Chin, 2005; Rosen, 2002), call centers (Buchanan, 2001), grocery stores (Tannock, 2001), child care (nannies) and housecleaning (Ehrenreich & Hochschild, 2002; Hondagneu-Sotelo, 2001; Ozyegin, 2001; Parrenas, 2001; Pratt, 2004), and increasingly, the hotel and hospitality industry (P. A. Adler & Adler, 2004; Sherman, 2007; Wells, 2000; Zuberi, 2006). Research on working poverty have revealed serious problems with these kinds of jobs, including low pay (England, Budig, & Folbre, 2002; Levitan & Shapiro, 1987; Shulman, 2003), limited or nonexistent benefits (Heymann, 2003; Johnson, 2002; Schwartz & Weigart, 1995; Zuberi, 2006), invisibility (Shipler, 2004; Tannock, 2001); serious material hardships (Edin & Lein, 1997; Hurtig, 1999), lack of affordable high-quality child care (Chaudry, 2004), and nonstandard work schedules that present challenges for combining work and family life (P. A. Adler & Adler, 2004; Presser 2003).

Much of the research on the working poor challenges “culture-of-poverty” arguments that often blame poor people for their own plight and exposes how the causes and consequences of poverty are embedded in the social system (Jurik, 2004; Munger, 2001). The conditions of work in low-wage service-sector jobs are shaped in part by government employment policies.

New Immigrants and Low-Wage Work

Recently arrived ethnic-minority immigrants to Canada and the United States are often at high risk of joining the ranks of the working poor. This is attributable in part to unique barriers to finding secure employment, including a lack of English fluency (Beiser, 1999), language accents (Creese & Kambere, 2003), unrecognized foreign work experience and credentials (Reitz, 2003), limited social networks (Waldinger & Lichter, 2003), and discrimination (Reitz & Breton, 1994). The research literature points to barriers experienced by new immigrants, a group particularly vulnerable to poverty and social exclusion (Milkman, 2006; Reitz, 1998; Wells, 2000).

Current debates about theories of segmented assimilation, which suggest that immigrants selectively adopt particular norms and values of their host society (Alba & Nee, 1997; Portes & Rumbaut, 1996, 2001; Rumbaut & Portes, 2001), have focused extensively on immigrant group–specific factors or immigration selection policies
(Borjas, 1993, 2001). There have been some exceptions, such as Fernandez-Kelly and Konczal (2005) that begin to examine how non-immigrant-specific structural barriers—such as discrimination—shape responses of second- and third-generation minority immigrant youth.

**Poverty, Insecurity, and Health**

Although the social determinants of health literature have identified macrolevel inequality as resulting in poorer health outcomes overall (Kawachi & Kennedy, 2002; Marmot, 2005), they have not carefully explicated the microlevel pathways that link these social phenomena (Adler & Newman, 2002). This research helps identify these links by focusing on interactions between poverty, isolation, stressful working conditions, and negative health outcomes, both in the short term and long term, for low-income families and their children (see Heymann, 2006).

Research has shown that job insecurity is detrimental to employees’ mental health (Kim, Muntaner, Khang, Paeka, & Cho, 2006; Marchand, Demers, & Durand, 2006). For all the glorification of Tom Peters’ (1999) “You are a brand!” ideal, the reality of increasing job insecurity in a postindustrial economy undermines the health of the workforce, especially for workers lacking specialized and valued skills. The expansion of low-wage contingent jobs is increasing hardship and insecurity among a growing number of working poor.

**Method**

**Participants and Site Selection**

Hospital housekeepers and other support workers perform critically important jobs for the health care system. For example, the job of a hospital housekeeper can include the postoperative disposal of body tissue and cleaning up of blood splatters, feces, and vomit to prevent the spread of infections (Cohen, 2001; Stinson, Pollak & Cohen, 2005; Messing, 1998). The findings are based on in-depth digitally recorded 1- to 2-hr interviews with 70 hospital support workers working in outsourced support jobs in Greater Vancouver hospitals. The interviews were completed between April 2007 and November 2009. Participants were recruited through fliers and invitations distributed at workplace and union meetings as well as through snowball sampling. Each semistructured interview was guided by a detailed interview protocol that included both survey-style and more open-ended questions.

The advantages of this qualitative approach is that it allowed the research team to collect data from a difficult-to-survey subpopulation with limited English language fluency and, in general, extremely limited time between work and family obligations. In-person interviewers could clarify questions and probe for more detail in responses. The open-ended sections of the interview generated rich data about how privatization affected these workers’ lives and their families that would not be possible to obtain through other methodological approaches.
Snowball sampling proved to be important for recruiting respondents to participate. The disadvantages of the snowball sampling approach is that it inevitably introduced certain biases, which are important to acknowledge. On one hand, the sample includes a disproportionate number of support workers active in workplace issues and with the union. These workers likely have more serious grievances with contracted-out employers and their work conditions. The benefit of working with the union is that it allowed access to the sample, which, given their complex employment arrangement under contracting out (working in a beeper system managed out of suburban office parks), would have been difficult or impossible to achieve. On the other hand, the sample also includes workers who are more confident in their English language fluency and excludes those most vulnerable new-immigrant employees who lack fluency, who are perhaps more likely to experience material hardship and exploitation.

**Sample**

Similar to the feminized workforce employed in hospital support positions, the sample is composed primarily (81%) of women. The average age of the respondents is 49 years old, and most (54%) are married or living common law. Another 24% are single and 17% are divorced or separated. The vast majority of interviewees (83%) are visible minorities, with Filipinos composing the largest group, at 46%. Most (88%) of the sample population are immigrants, 52% of whom arrived in Canada before 1991. The majority (60%) of participants in the sample population are well educated with at least some postsecondary education. The respondents interviewed for this study work in hospital housekeeping and food service departments, mainly as housekeeping or dietary aides.

**Data Analysis**

The survey data from the interview protocols were tabulated, and the interview transcripts were coded and analyzed with qualitative research software (NVivo8). First, emergent or open coding was conducted to identify themes and patterns in the interview transcripts (Berg, 2007). After determining the key themes of interest, the research team initiated focused coding to develop subtopics, identify links, and distinguish variations (Creswell, 2007; Emerson, Fretz, & Shaw, 1995). Finally, analytic themes and connections were further scrutinized and elaborated within theoretical frames.

**Results**

**Challenges Making Ends Meet**

Many respondents reported facing serious challenges making ends meet on their wages as outsourced hospital support workers. These wages were reduced from approximately $18 per hour to between $9 to $12 per hour in the aftermath of contracting out. With
a new union contract, their wages have now increased to approximately $13 per hour, but many workers are unable to secure full-time hours. As a result of low hourly wages and an increasing reliance on “casual” or “on-call” employees, 68% of respondents earned less than $30,000 per year, and 14% earned less than $20,000 per year. Thirty percent of the respondents interviewed indicated that they had to hold more than one job. Some turned to second and even third jobs, credit, and relatives to help make ends meet, but despite these resources, many came up short every month.

When asked if she had any savings, 43-year-old housekeeper and dietary aide Carmela Hilota replied, “No. I cannot! I don’t have anything to save. It’s just like the money that I’m getting right now is just too . . . almost not even meet both hands. It’s just like this (gestures hands almost touching), it doesn’t meet.” Experiencing challenges in making ends meet caused her to turn to credit to get by. She has used her line of credit: “It’s full! The only thing I can pay is the interest (laughs nervously). . . . $12,000 and it’s full. I borrowed everything.” Carmela Hilota is a single mother supporting one child. She has two credit cards and carries a balance of “$3,000 and the other one is $1,000 plus” in addition to a car loan with high monthly payments. Carmela reported that she cannot turn to relatives for loans or financial help because “they don’t have money.” Instead, she has turned to a strategy typical among the working poor: working multiple jobs to attempt to bridge the gap in expenses and earnings. She said,

Oh because I worked three jobs last year, they’re saying I don’t even sleep any more. I worked 7 days a week, . . . from 6 o’clock until 12. That is nonstop, I got only . . . I think break for 1 hour. And I got, I think $46 [thousand], but that is no day off at all, no life.

Working multiple jobs is one consequence of the low wages for health care support workers, and the strain and exhaustion it causes not only reduces quality of life but also raises the risks of mistakes, accidents, and poorer-quality work.

Working multiple jobs simultaneously is not only exhausting, but it can quickly become unsustainable. After last year, Carmela Hilota, said,

I did the half-year for that one [three jobs] and I stopped because I feel very, very weak already and I got sick. So I stopped the other one, so I am just working two jobs now. . . . Yeah, because I can not [any] longer. I wanted a day off too, even half a day.

She dropped one job, which reduced her annual earnings to approximately $38,000 for the year, which has had the consequence of making it very difficult for Carmela Hilota to pay her bills. She explained,

Very, very difficult . . . On the first of the month, I’ve got a headache, and all my accounts all negative. Most every month, my account is negative balance . . . because I stopped [working one of] my one jobs, so it doesn’t meet [my
expenses] anymore. Before it can meet, now it doesn’t. I really need three jobs, but my body... it cannot function anymore. I do not want to get really get sick.

The strain of work so many jobs simultaneously threatened Carmela Hilota’s health. Although outsourced hospital support workers earn more than the minimum wage in British Columbia, they earn approximately two thirds of the hourly wage that they earned prior to outsourcing. Many workers interviewed described their earnings as falling short of a living wage sufficient to provide material security or a decent quality of life. Indeed, more than 70% said that it was either somewhat or very difficult to pay their monthly bills. Emma Sanchez, a 60-year-old Filipina housekeeper, explains:

That’s the problem, like I’m having a problem again with the paying tax, my credit card because right now it’s just enough, it’s just like both ends meet on this kind of earning that I have. Eh? Yah, I can go through, but it’s just like there’s not much left over, or not much extra to save.

Many of these employees are parents of young children and thus require resources as working parents. Thirty-six-year-old Angie Kristham, a full-time housekeeper and mother of two children, ages 4 and 8, said,

Regarding... pay, they are just paying $12 [per hour], and that’s... not much. Because it’s very hard for us to survive... in these days, because everything [cost of living] is going up. Even for kids, because now my son has to go to the preschool, and I was just thinking, do I have to send him or not, because I have to pay some money... every month maybe around $150. So I think it’s very hard.

Even with subsidized child care for low-income families, child care and other child-related expenses remain a heavy burden on working poor families.

Low wages also have important implications for housing. To save on living costs, some respondents reported living in crowded housing, sharing accommodation with their extended families, international students, renters, or even multiple families. In addition, 85% experienced at least some problems with the condition of their housing, ranging from leaky roofs to broken appliances. Because affordable housing can be located in more high-crime areas of the region, some respondents reported a diminished quality of life resulting from fear and perceived isolation. The nonstandard shifts that some respondents worked contributed to this sense of social isolation. Juanita Romero, a 55-year-old Filipina housekeeping aide, felt unsafe in her neighborhood:

“At night time, I walk so fast... I watch... behind me because I’m walking from there, and it’s very scary because people are walking. My son wants me to move, but we cannot afford to.” Despite Vancouver’s relatively high levels of investment in neighborhood infrastructure and its emphasis on community centers and parks, several respondents reported feeling insecure or unsafe in and around their neighborhoods.
Fifty-seven percent of respondents reported that their work schedules made it difficult for them to spend time with their families or to participate in community life. For example, housekeeping aide Juanita Romero lamented, “I don’t get to see my kids very often. I’m always working night, and them working days.” She also said her job schedule limited her social life. She explained that was the case “because of the fact that I don’t have evenings off. I am just going to have to find some guy who works the same shift as me.” Additionally, she feels she does not have time to attend church: “No. I don’t go. I’m religious, but I don’t go. I find when they’re all in church, that’s when I get a chance to get my laundry done!”

**Job Stress**

There is a misperception that these kinds of jobs, like many others in the feminized low-wage service workforce, do not require skills or physical exertion. The reality is that these jobs are highly strenuous both physically and emotionally. Hospital support jobs demand a great deal of strength, stamina, and physical exertion. Housekeeping aide Peter Wu pointed to the linen bags they have to carry:

> It’s all the linens because it’s close to 50 maybe 60 pounds sometimes. What’s happening, we change the linens quite often. For instance, a burn patient, keep changing . . . and also for . . . a patient, who use those bags. It’s very heavy sometimes.

Housekeeper Angie Kristham described the fast pace and lifting required as strenuous. She said, “We [are] just running from one floor to six floor. Just running and running . . . We have to lift [bags of] linen and garbage too. Sometimes, the linen is very heavy.” She said,

> We are just working because we want to survive. We want to eat! If we are just running around, we don’t have even [have time] to take a break. We’re just running like a horse; (laughs) we don’t even [have time] to eat. So I’m thinking there’s too much work.

Overall, respondents described work intensification since the outsourcing of their jobs, caused largely by problems with understaffing.

Overall, the respondents report that the work is extremely physical and challenging. On a 7-point scale of physical exertion, with 1 being *light* and 7 being *extremely heavy*, 56% of the workers rated their jobs a 7, and 90% rated their jobs as 5 or above. The heavy physical workload was a significant source of stress for many of the workers interviewed. When asked if she generally had enough time to get her work done, 47-year-old dietary aide Colleen Lanta replied,

> I just make it. You know honestly, . . . I don’t really want to do it, but I don’t have choice, it’s too much, the load is too much. If I do it, because I’ve been
doing the job for almost a year and I’m fast to do it, to do that job. If I phone in sick, if I’m sick or if I take time off, two people are doing it.

Sixty percent of respondents shared Colleen Lanta’s concern that they lacked sufficient time to complete their assigned tasks.

Working in a hospital setting or other acute care facility can also challenge a person’s mental and emotional well-being. Simply being surrounded by suffering, death, and tragedy can be a challenge. Whereas some only briefly interact with patients, others spend more time around them while cleaning rooms, for example. Housekeeper Angie Kristham explained:

I’m working in the cancer [area], when we saw the patients, sometimes they are very small kids. Then sometimes I just feel scared . . . emotional. To see that little kid, how they are . . . So I’m thinking about my kids, that they’re just like my kids. . . .

Sometimes I see the patients when they are very sick, mostly on the fifth floor. The patients, sometimes they die over there. Then I feel very stressed to see them; then the family comes and they are just crying and crying. Before I started . . . I got training for 2 or 3 days. I saw . . . someone has died over there. I was thinking, I should quit my job, because I can’t see that kind [of thing] . . . because they are just crying [the] family, behind them. Then slowly . . . I think, “Ok, I have to work!” Sometimes I just feel to cry, when I saw that.

Andrea Sharpe, a 57-year-old housekeeper, said that emotional experiences related to the job in addition to her work and financial conditions have had deleterious consequences for her mental health. She recalled,

There were some days when, especially at [the] cancer [area], I’d get up, my hands were shaking so bad I couldn’t even put my makeup on. . . . It was related to work. . . . I worry about everything, finances, my car, just everything . . . I couldn’t even sleep. There would be nights I didn’t sleep all night long. I would come home from work; I’d stay up watch TV, play solitaire on the computer until 3 in the morning. I’d go to bed and lay there and lay there and look at the clock, 5 o’clock, 6 o’clock, 7 o’clock. Never slept at all.

At the same time, interacting with patients can be among the most rewarding aspects of an challenging job. Andrea Sharpe also said, “Well, I’d hate to think that that’s my major skills is cleaning toilets and washing floors. But the other part that I like is keeping making the kids happy and getting smiles out of them. That makes me feel happy.”

Housekeeping aide Melissa Mittal explained that the stress of inspections and audits added to on-the-job stress:
Sometime we’ve got people coming around doing audits making sure we get every nook and cranny clean and everything is perfect. Because [if] we don’t have every nook and cranny clean or dust our area, we get a fail mark. The company gets a fail mark.

As a result of the physical demands of the job, Melissa Mittal reports that she frequently “get[s] migraines” and carries pain medication on her all the time at work. Although such mental or emotional challenges are not unique to outsourced or privatized hospital jobs, they are an additional source of stress for many workers. It should also be noted that prior to outsourcing, when these workers were employed in-house, they were considered a part of the health care system and had stronger social links with other health care staff, such as nurses, to whom they could turn for support. They also had more time to linger and talk and get to know the patients in their wings. They were not constantly rotated and not as rushed—and certainly not as isolated on the job as they are today. It is clear how outsourcing has worsened the emotional side of the job.

**Injuries and Illness**

Workplace hazards for hospital cleaners abound. The physical work can be arduous, putting workers at risk for strained backs, bruises, breaks, repetitive stress injuries, and abrasions. The patients themselves can, unfortunately, be dangerous. For many, there is a constant concern about handling biohazardous materials and the possibility of being pricked with a contaminated needle. Beyond these dangers, working in these jobs also entails frequent exposure to viruses, communicable diseases, and hospital-acquired antibiotic-resistant infections. Carmela Hilota said,

> Oh I was assigned in OR [the operating room], I got the job routine in OR, which is a critical area, and it’s not really safe for my health. It’s not really safe for the health because in the operating room you are exposed to disease. And you know how much they pay us.

The hospitals use color-coded signs to warn contract employees about patient hazards. According to 43-year-old dietary aide Anita Treuta, when employees deliver food to a patient room, they first have to check the color of the sign on the door. She said,

> We have the sign on the door . . . if it’s pink, it’s airborne, then don’t go in. We only go if it’s yellow because then we wear gloves. If it’s pink, we put it [food tray] in the nursing station and the nurse will be the one to go inside.

In the event of airborne infections in a patient room, a nurse will bring the food in. This kind of system constantly reminds employees of the potential dangers of their job, even as it protects them. Housekeeping aide Bonnie Kruja describes the wing she cleans as “like a dangerous place. We have to wear two pair of gloves, and protect ourselves.”
These service-sector jobs expose workers to risks of illness and injury; 63% of respondents interviewed reported being injured or getting sick on the job.

Some of these injuries might appear trivial on the surface but happen with shocking frequency and can have long-term consequences. For example, Jasmine Chaudry, a 38-year-old housekeeping aide and mother of three children, fell down some stairs at work and injured her heel. She had to stay home 3 days to recover. When she returned to work, “then I got a needle stuck on my hands.” Indeed, for hospital support workers, daily responsibilities involve the ongoing risk of injuries ranging in severity from mild discomfort to serious injuries with lasting consequences. Dietary aide Sofie Cuaro was injured on the job working in the kitchen. “When I tried to grab the box of waffles, frozen waffles hit my forehead,” she said. In another incident, Sofie Cuaro’s foot was also injured when run over by a heavy cart. She ended up taking 2 weeks off work as a result. Fortunately for Sofie Cuaro, her time off work was paid for by the Workers’ Compensation Board insurance. Despite the paid time off to recover, she still experiences repercussions from her injury. “When I got injured, now I have a hard time walking,” she said.

Workplace injuries can have a lasting and detrimental effect on a worker’s quality of life. Some continue to suffer long-term health complications or chronic pain. Injuries and strains can make it hard to complete job tasks. Dietary aide Colleen Lanta said, “Because my back is hurting already, when we do the [food preparation tray] line, 2 hours everyday for the hard job, it’s difficult for me.” Housekeeper Andrea Sharpe described getting injured on the job. She said,

I was trying to empty the [bin]. We had great big [bin], I had a lot of garbage in my area, a lot. And we had these huge bins. So I’d have to lift in, from a small one, lift them into a big bin and take them outside to the loading dock, tip it, and put it into a compactor. Well when I did that, I tipped it and even before—then I thought, “Oh my god, my back!” And even before that, I guess it was getting strained because everybody at work was saying, “Oh look at you, you can’t even stand up straight!” Because at the end of the shift I was walking around like this [walks around room with shoulders hunched and back crooked over]. Like a little old lady! . . . So I went to doctor right away and filed for workers’ comp. That’s when they found out. They thought it was just strained, . . . and then they found out it was a fractured vertebrae. I don’t know how long I was walking around with that fractured vertebrae.

Andrea Sharpe ended up off work for two and half months as a result of her back injury. Even when she was ready to return to work, she had to work under strict restrictions from her doctor. She explained,

There was a physiotherapist and he made up a program that when I came back, and he told her [the supervisor] in front of me, he said, “You strictly have to stick to this. When [Andrea] comes back she’s not allowed to lift this, she has
to have somebody helping her. She can only work for 4 hours. Then it is going to gradually go to 6 hours, but she’s still not allowed to lift this. And don’t you dare force her to do anything that’s not on this list.” But you could tell by the way she [the supervisor] looked at me that she was not happy at all.

The Workers’ Compensation Board covered her lost wages when she was recovering and in the transition back to full-time work. She said,

It was just too heavy a work. I mean I’d try and lift up these huge bags. They’d be so heavy, like with medical journals and things like that all in it, that they’d just collapse on me all over the floor. It was just too much.

Although Andrea Sharpe is back at work full-time, she is still haunted by her back injury. “Well, I’m still hurting!” After cleaning her house yesterday, her back is sore today.

Like yesterday I got a cleaning binge here, and now my back is paying for it today. Because I scrubbed down my walls and my cupboards and stove and all that kind of stuff, right? Washed the floor . . . so now I am paying for it today.

Many of these workers suffer long-term pain attributable to on-the-job injuries. Before these jobs were outsourced to private companies, support workers could participate in on-site health and safety committees, which could provide recommendations to make their job routines more safe and where they could report problems. The subcontracted nature of the outsourced jobs has eliminated these organizational structures, although the Hospital Employees’ Union that represents these workers is attempting to reconstruct them in contract negotiations.

Several workers reported being pressured by management to refrain from reporting their injuries or filing Workers’ Compensation Board claims. This is because the companies’ Workers’ Compensation Board insurance rates are contingent on the number of claims filed by injured workers. There are two possible strategies to reduce the number of workers’ compensation claims. One is to strive to make the workplace and jobs as safe as possible. The second is to take steps to minimize the numbers of claims filed through misinformation, losing paperwork, and intimidation. Khalid Imani, a 43-year-old hospital cook, described a situation he observed at work. He said,

A lady who burned her chest right here. Over here, one of the supervisor told her, “OK, just put some ice on it, don’t mention it to anybody.” And the next day when I went, she cried to me, and I basically shout at the production manager. I said, “That’s totally unacceptable.” I said, “Are you trying to save a couple bucks for the company not to pay for the workers’ compensation? If this lady got really burned, got some infection, when she goes to the [emergency], they are going to ask her how it’s happened. She has to give a report. Then how
[are] you [going to] save yourself? Even the company [will go] down the drain now. What are you trying to save by abusing others?"

Unfortunately, the profit motive introduced by privatization can act in these cases against the best interests and well-being of the employees, many of whom are recent immigrants with limited English language fluency. As vulnerable workers, many lack a thorough understanding of their legal rights and protections under the province of British Columbia labor code.

In the privatized model, there is no incentive to maintain a surplus pool of trained workers to fill in for absent or ill workers. For the multinational corporations that successfully bid for hospital contracts, the lower the labor costs, the higher the profits. This “just-in-time” staffing model is designed to work best when workloads are stable and increases and decreases in demand are predictable. In the health care setting, where a highly contagious flu can sicken many workers at once or dramatically increase the workloads, the “costs” of maintaining minimal staffing surpluses land on the workers, who are regularly asked to work overtime or to complete the work of two workers in one shift.

Housekeeper Bonnie Kruja recommended, “Why not the company hire somebody like 4 hours [on] a regular basis right, to cover like, emergency cases, right?” Having extra staff available to cover the frequent emergencies would help ease the strain dramatically; it would also reduce the profitability of the outsourcing contracts, which is based on keeping labor costs as low as possible. Bonnie Kruja also felt that they should anticipate predictable employee illnesses and absences. She said, “Sometime one person is like sick . . . and sometime, there’s no people show up. . . . They should hire like more people to stand by.”

Of course, contracted-out workers need time off not only when they themselves are sick. The large majority support other dependents, who require their care and attention when they are ill. Under the current system, because many of these employees know that the supervisors are unlikely to give them permission to take time off even if requested in advance, they do sometimes use sick days when they are not ill. Dietary aide Colleen Lanta explained,

Sometimes they give me the time off, but if I know that there’s not enough people [working], I phone in sick [instead]. Because most of the time, we don’t have enough people. For sure they won’t give me the time off. One hundred percent.

Colleen was frustrated that she could not get time off. She said,

They won’t give you [time] off! . . . Unless, if I’m very sick, I just phone in sick . . . But sometimes you’re tired every day, every single day and my job is quite hard. And our sick time is only 6 days [per year] and it’s not enough. And one thing more, when we’re sick, they’re just thinking that we’re making it up. I
hate that. I hate that. Yeah, and they even ask, ["Are you really sick?"] like sometimes. When you get up in the morning, and your body is so tired and you feel pain and there are times when you don’t want to go to work because you really feel sick. For 1 day, they’ll ask you a doctor’s certificate, and the doctor asks $10. They won’t even repay you!

Under the current employment regime, there is considerable conflict regarding time off, both among employees and between them and their supervisors. The requirement of a doctor’s certificate or note for a missed day’s work causes many employees just to show up to work sick, a danger to the health of patients and coworkers.

The constant exposure to contagious diseases sets apart health care jobs from other employment sectors. The risk goes beyond constant colds and flus. Housekeeper Angie Kristham is upset that contracted-out workers in hospitals do not receive any special consideration because of their exposure to diseases. She said,

I was thinking, the wages [are] very low. We are working always in the risky one. We don’t know what time we can get . . . disease from patients, or something like that; because . . we never know, right? Sometime we are doing MRSA [an antibiotic resistant bacteria], like a TB patient is there; we don’t know what time we are gonna get sick, right. So we don’t have any security for our life. . . . How we can secure our life?

Whereas care workers who are directly employed by the government receive free annual TB screening tests, outsourced workers must take their own precautions and know to carefully monitor their own health on their own time.

Long hours, physically and emotionally demanding work, and ongoing exposure to viruses and infections can be difficult for anyone who works in the hospital setting, whether at the top or bottom of the hospital work hierarchy. What is unique about the challenges faced by outsourced support workers is that they now work for private companies whose aim is to make profits off of their labor rather than simply to run a hospital as efficiently and effectively as possible. With so few measures taken to ensure their health and well-being, workers are stressed and overworked and may lack sufficient resources to maintain a healthy lifestyle and diet or to live in a safe, well-maintained home. With such an arrangement, these workers at the very bottom of the hierarchy are among the most at risk in the health care workforce.

**Job Insecurity**

Despite the fact that the workers were unionized, concerns about job insecurity figured prominently throughout the interviews. Housekeeper Paola Rozero described this as a consequence of outsourcing these jobs. She said, “Really, I don’t even know if I’m going to have a job by 2008.” As a result of a her company’s poor performance on a recent audit, she worried its contract with the hospital would not be renewed.
Although she said, “I’m not surprised at all” about the poor outcome, it brought home feelings of insecurity “because I don’t know what’s going to happen in a year or so.”

Outsourced workers are fully aware of the precariousness of their job security. Housekeeping and dietary aide Rosa Bunter remarked, “We’re not Coastal Health [public] actual employees, . . . that’s why . . . there’s always audit all the time. If we always fail, we going to lose the contract, [and] losing contract, [means losing] our job.”

The Hospital Employees’ Union won major legal victories that challenged the legality of voiding employees’ previous collective agreements, which included restrictions on job outsourcing. Ironically, this legal success exacerbated these workers’ job insecurity within this already contingent workforce. As housekeeper Angie Kristham explained,

The previous . . . employees, what if they come back. Then everybody’s thinking . . . maybe we will get laid off, something like that. So everybody’s thinking maybe in the future we don’t have any jobs in hospitals. So that’s why we want the job secure.

In the end, the legal settlement did not reverse the outsourcing and contracts. The previous in-house support workers, negatively affected by privatization and outsourcing of their jobs, received financial and other kinds of compensation, such as retraining.

Despite union victories, the prospect of job loss remains a persistent source of stress for many contracted-out support workers. As housekeeping aide Juanita Romero pointed out, “Because that is a private sector [employer], any time the company wants to close the door, then we are all done.” Cook Julio Marquez, who had previous experience of just such an event in his country of origin, recalled, “The private company one day they can say, ‘We don’t have enough profit.’ I live this situation before . . . in the . . . company, [in which] I work[ed]. . . . When they privatizing, they [laid off] 500 people.” Isabella Tacata, a 51-year-old who immigrated to Vancouver in 1991, explained that the precarious situation for workers’ futures is now also increasing in health care, which used to be a stable sector. She said, “Before . . . you can retire in a hospital setting. . . . Now, what will happen to me for my retirement? . . . They kept on privatizing everything. There is no security.”

Policy Reforms

The findings point to several concrete policy recommendations to improve the lives of workers. These policy recommendations include the following:

- Increase and index the minimum wage, as this increases wages even for workers earning more than this floor.
- Ensure that cost savings from outsourcing do not result from wage and benefit cuts to the most vulnerable workers through the establishment of wage floors and living-wage agreements.
Monitor the working conditions and wages of people working in the health care system on contracts in addition to quality inspections. Provide training opportunities for those working in the health care system to upgrade their skills and expand their job responsibilities. Raise marginal tax rates on high-income earners and close tax loopholes to fund income supplements and other transfer programs to improve the quality of life for the working poor and near-poor.

These policies are only the beginning. Bringing back (or keeping) these jobs “in-house” would not only result in improved working conditions for these employees but also allow for the maintenance of greater capacity to deal with crises or to improve training and routines to improve infection control.

Concluding Thoughts About Outsourced Hospital Workers

Given the dramatic shift to the service sector in advanced industrial economies in the past four decades, examining the effects of outsourcing low-skilled public-sector jobs to multinational corporations is critical for understanding how neoliberalism has resulted in increased poverty, inequality, and social exclusion in these countries during periods of economic affluence and growth.

The findings provide a case example of the role that outsourcing plays in the construction of labor market segmentation and the development of increasingly divided core and periphery labor markets within advanced industrial countries (Doeringer & Piore, 1971) and deskilling (Braverman, 1974). Outsourcing is a relatively new organizational form, particularly, its adoption by governments. These findings generate valuable data to assess its impact on workers and on other broader social consequences, such as the children of recently arrived immigrants working in these jobs.

The findings of the Hospital Support Workers Study expose the broader structural factors—particularly, employment and social policies that affect immigrants and non-immigrants alike—and explicate how these factors shape the challenges and resources facing new immigrants in Canadian and U.S. society. The conditions of work in the new labor market do not auger well for the fortunes of the second generation, and there are negative consequences of low-wage service-sector employment on the children of visible minority immigrants as their parents work long hours for low pay and their own limited economic fortunes.

Although much public and academic attention has focused on the deleterious consequences of the globalization of manufacturing for the wages of low-skilled workers, this research addresses the central role played by the outsourcing of feminized service-sector job positions in increasing poverty and inequality in Canada and other advanced industrialized countries.

As traditionally secure and living-wage jobs in the service sector are outsourced to private multinational companies, these companies are extracting greater profits by exploiting and underpaying contract workers, who are often not paid a decent wage,
given benefits, or provided decent working conditions. These companies are global and their profits are in the hundreds of millions. Their growth and expansion, particularly in the public sector, is a central part of the global neoliberal agenda.

The government health authorities, like many other institutions, outsource low-skill work to private contractors to shift responsibility and generate short-term cost savings. Private companies get away with paying low wages and offering limited benefits in part because their jobs are largely filled by ethnic-minority women and immigrants whose options are limited. Ironically, in Vancouver, advocates of privatization argue that hospital support work is almost exactly the same as hotel room cleaning, which it certainly is not (Cohen, 2001). Despite that, most hotel cleaners in Vancouver now earn far more than hospital support workers.

Although these corporations can and should be required by policy makers to provide decent compensation and conditions to their employees, it is unlikely they will do this without either facing pressure or the threat of strike from unionized workers or legislation that sets wage floors on government contracts and so on. With the encouragement and participation of the Hospital Employees’ Union, many outsourced hospital workers have taken an active role in the recently launched living-wage campaign in Vancouver, modeled after the living-wage movement in London, England (see Richards, Cohen, Klein, & Littman, 2008). But much more has to be done in both Canada and the United States to ensure fair wages and working conditions for workers at the bottom of the service-sector hierarchy.

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