Aged Care Institutions Management: A study of management’s engagement strategies to support migrant careworkers’ delivery of quality elderly care.

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Abstract

One of the most significant phenomenon in Western industrialised societies today is a demographic shift towards an ageing population. Improved access to better nutrition, medical care, and a growing awareness of the importance of healthy eating and exercise, have all contributed to increased life expectancies (Hussein & Manthorpe, 2005; Stone, Dawson, and Harahan, 2003). The increase in the number of those aged 65 and above has in turn led to a dramatic rise in demand for aged care services. In the same vein, the factors that account for increased life expectancies have also caused a reduction in fertility rates resulting in reduced numbers of young people who, ideally, should look after the ageing members of the population. The elderly dependency ratio has therefore continued to rise (Badkar, Callister and Didham, 2009; Hussein & Manthorpe, 2005). Coupled with this are trends that show that increasingly less young people in most of the Western industrialised world consider caring for the elderly an attractive career to pursue. To compound this elder care labour supply problem, it has become evident that most households are also growing smaller and becoming more geographically mobile as family members move around seeking better work opportunities. This has culminated in the formal and informal care-workforce failing to cope adequately with the burgeoning demand for aged care services (Walsh and O’Shea, 2009).

In response to the growing gap between caregiver supply and demand, the Western countries, New Zealand included, have increasingly resorted to the employment of migrants as carers. From an academic perspective, very little is known about the implications of the increased participation of migrants in elder care delivery because research in this field is still in its infancy. In this regard, this qualitative research explores the management implications of the increased internationalization of the workforce in the Aged Care Sector in New Zealand especially in the context of quality care conceptualisation and delivery.

The literature reviewed raised a number of fundamental issues regarding migrants’ participation as carers in the aged care sector (Walsh and O’Shea, 2009; Cangiano et al., 2009; Spencer, Ruhs, Anderson, & Rogaly, 2007). One of these issues is that the participation of migrants has introduced an intercultural element to how elder care is conceptualised, delivered, consumed and judged. The influence of culture on quality care delivery is further complicated by the largely intangible dimension of care. In this regard one of the major challenges impinging on the delivery of quality care, ironically, emanates from the elusiveness of the concept of ‘care’. Most of the extant studies show that elderly patients
value the intangible dimensions of care, such as communication, attitude and tone of voice, more than the technical aspects of care provision (Perucca, 2001). However, because of the participation of migrants as carers, the definition of what is ‘acceptable attitude’, ‘acceptable tone of voice’ or ‘quality care’ is less certain. Accordingly, the literature prompted questions about the multifaceted cultural contexts in which practices and conceptualisations of elder care occur as well as the cultural competences that may be needed by managers to aid migrants to deliver acceptable levels of quality care.

The tensions inherent in the elusive concept of care vis-à-vis migrant participation are further accentuated by other diverse challenges such as underemployment, perceived discrimination and perceived racism that most migrant carers face. These challenges that migrants encounter prompted questions about the role of managers in ensuring that these challenges do not impact negatively on how migrant carers provide care to the elderly.

To inform and structure this study’s exploration of the implications of the increased participation of migrants as carers, as well as informing the analyses of the responses of managers, the study made use of a Human Resource Management (HRM) conceptual framework. The HRM framework also emphasised the strategic role of human resources management in helping aged care institutions to achieve a sustainable competitive edge over others (Barney & Wright, 1997; Barney, 1995).

Methodologically, the exploration of the managers’ experiences with migrant carers’ employment is approached within the ‘interpretivist’ framework of inquiry (Crotty, 1998). The framework supports this study’s ontological perspective to the effect that there is no single, but a multiplicity of realities that are constructed by the participants (Crotty, 1998; Creswell, 1998). This perspective of knowledge and reality lends itself to a qualitative research design in which the researcher plays an important role in exploring in a natural setting, the varied perceptions of managers. The study therefore made use of in-depth personal interviews with 16 managers and unit nurse managers in elder care facilities in the specific location of Dunedin. In this case, the managers as well as the interviewer contributed to the creation of multiple realities regarding the employment of the migrant carers.

Notwithstanding their admission that the participation of migrants as careworkers has improved quality care delivery, the managers highlighted the legal requirements of employing migrant workers such as VISAs/work permits, perceived racism and discrimination,
underemployment and poor English proficiency skills of most migrants as major challenges compromising quality care.

As regards the management intervention strategies to deal with the challenges, the study found that most managers made attempts to help migrant care workers to fit into the organisational culture. Some of the managers helped with the processing of the work permits. Other managers highlighted the need to provide job resources to lessen the burden of carework. The other managers however showed that they had not taken time to appreciate the unique challenges that are faced by their migrant cohort of workers and therefore had no visible strategies in place.

These findings indicate the need for different stakeholders such as New Zealand Immigration, Ministry of Health, aged care sector, facility managers and the tertiary education sector to engage further in order to emerge with strategies that may make the employment of migrant workers less cumbersome thereby minimising disruptions to the quality of care delivered to the elderly.

This Dunedin City based study’s findings provides some useful insights about the managers’ perceptions regarding the role of migrant carers in quality care conceptualisation, and management, in a multicultural aged-care provision environment. It is however suggested that in order to develop a comprehensive picture of the impact of migrants on elder care delivery, further studies be undertaken focussing directly on unravelling the experiences of the migrants carers from their own perspectives.
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TO GOD BE THE GLORY
Chapter 1: The Research Context

1.1 Introduction

One of the most significant phenomenon in Western industrialised societies today is ageing. Improved access to better nutrition, medical care, and a growing awareness of the importance of healthy eating and exercise, have all contributed to increased life expectancies and decreased fertility (Hussein & Manthorpe, 2005; Badkar, Callister and Didham, 2009). In this context, it is estimated that in Europe, the number of people aged 65 or more will rise from 16 percent in 1999, to 21 percent of the population in 2020 and to 28 percent in 2050 (Schulz, Leidl, and König, 2004). Statistics of the ageing in New Zealand share similar trends (McGregor, 2012).

There are some significant implications worth noting that emanate from of these population age structure changes. In this regard, one of the most significant results is the dramatic rise in the demand for long-term care services, with serious implications for the capacity of the health care systems to adequately provide these services. Whilst on one hand, better access to improved nutrition and better medical care has led to more people living longer, on the other hand, reduced fertility rates added smaller cohorts to the younger age groups (Cohen, 2003). The irony here is that the young able-bodied people are the ones who would be expected to look after the aged. The reduction in fertility rates has therefore caused the elderly dependency ratio (the ratio of the number of people aged 65 and older to the number aged 15 to 64) to continue to rise. Coupled with this problem, is that most of these young people in most of the Western industrialised world do not consider caring for the elderly an attractive career to pursue (Eborall, 2003; Cangiano, Shutes, Spencer, & Leeson, 2009). It has therefore been observed that, in light of this burgeoning demand for long term institutionalised aged care, the formal care-workforce in Western industrialised countries has not been able to cope (Eborall, 2003; Stone, Dawson, and Harahan, 2003).

To compound the problem, is the fact that most households are growing smaller and becoming more geographically mobile as people move around in search of better work opportunities (Massey, Arango, Hugo, Kouaouci, Pellegrino, & Taylor, 1993). The family unit is continuously losing its capacity and capability to look after its own aged. In response
to the growing gap between caregiver supply and demand, the Western countries, New Zealand included, have increasingly resorted to the employment of migrants as carers.

However, from an academic research perspective, it can be argued that very little is known about the experiences of managers of aged care institutions who, on a day to day basis, work with these migrant carers in delivering care to the elderly patients (McGregor, 2012). Research in this field is still in its infancy. The increased participation of migrants as carers therefore continues to raise some fundamental issues that require some investigation. In this regard this study explores, from the perspective of managers of aged care institutions in Dunedin, the implications of employing migrants as carers especially in the context of quality care delivery.

By way of progress, this chapter will discuss in detail the factors accounting for the increased need for aged care institutions especially in the Western industrialised nations. This increase in the number of the aged has also met with stiff challenges in local labour supply. The chapter will then look at the responses of the Western industrialised economies to fill the void which invariably has seen most of them relying more on the migrants. Some insights into the migration phenomenon will then be provided, emphasising the complex issues underpinning migration and migrant workers’ experiences. In addition, New Zealand patterns of immigration and policy perspectives will be explored. Overall, the chapter establishes that globally, demographic pressures dominate the direction of demand for aged care, aged care facilities and the requisite labour supply. The participation of migrants as carers and the challenges that emerge thereof regarding management of aged care facilities to ensure aged care quality delivery, should therefore be understood in this context.

1.2 Aged care sector growth: Accounting for the rise in need for aged care institutions

The aged care sector, especially in most Western industrialised economies, has recorded some phenomenal growth in recent years. As of 2009, there were 5.6 million adults aged 85 years and older in the United States (U.S. Census Bureau, 2011). It is also reported that as of 2010, there were just under 81 million baby boomers ranging in age from 46 to 64, constituting more than one-fourth of the U.S. population (Barrows, Powers and Reynolds 2012). In this regard it is estimated, for example, that by the year 2030, in the USA, there will be about 71 million older adults accounting for nearly 20% of the U.S. population (Centres for Disease Control and Prevention (CDC) & Merck Company Foundation (2007). Another report
estimates that by 2020, 20% of the U.S. population will be made up of persons aged 65 (Judy & D’Amico & Geipel, 1997).

Figure 1.1 below illustrates population age changes in USA from 1950 and estimated up to 2050.

![U.S. Population Ages 65 and Older, 1950 to 2050](image)

**Figure 1.1: USA population age structure changes**

Source: Jacobsen, Kent and Mather (2011, 3)

Figure 1.1 shows that the number of people aged 65 and above is predicted to continue to rise. This USA scenario is to a large extent replicated in many of the Western industrialised counties like Italy, Japan, UK, Australia and New Zealand (see also Walsh and O’Shea, 2009). In this regard, a research done in Italy by Lamura, Chiatti, Di Rosa, Mechiorre, Barbabella, Greco, and Santini (2010) established that the problem of the aged care sector is very acute as one-quarter of that country’s population is currently over sixty.
In the same vein, Figure 1.2 below shows the projected population changes between 2005 and 2050.

<table>
<thead>
<tr>
<th>Country</th>
<th>Projected Population Change 2005–2050</th>
<th>Percentage of Population Age 80+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age 15–64</td>
<td>Age 65+</td>
</tr>
<tr>
<td>Australia</td>
<td>+19.9%</td>
<td>+159.5%</td>
</tr>
<tr>
<td>Austria</td>
<td>-23.4%</td>
<td>+63.7%</td>
</tr>
<tr>
<td>Canada</td>
<td>+9.4%</td>
<td>+159.2%</td>
</tr>
<tr>
<td>Germany</td>
<td>-24.9%</td>
<td>+44.1%</td>
</tr>
<tr>
<td>Italy</td>
<td>-38.6%</td>
<td>+55.9%</td>
</tr>
<tr>
<td>Japan</td>
<td>-38.2%</td>
<td>+59.4%</td>
</tr>
<tr>
<td>Norway</td>
<td>+5.0%</td>
<td>+90.6%</td>
</tr>
<tr>
<td>Spain</td>
<td>-32.5%</td>
<td>+104.5%</td>
</tr>
<tr>
<td>Sweden</td>
<td>-4.8%</td>
<td>+59.8%</td>
</tr>
<tr>
<td>UK</td>
<td>-1.2%</td>
<td>+63.3%</td>
</tr>
<tr>
<td>US</td>
<td>+27.2%</td>
<td>+122.1%</td>
</tr>
</tbody>
</table>

**Figure 1.2: Projected Changes in Population Characteristics in some Western Countries 2005 - 2050**


Figure 1.2 shows that, in Japan for example, the percentage population will increase from 4.5% to 16.7% by 2050. In some countries there is going to be a decrease in the age group 15-64. For example Austria, Germany, Italy, Japan, Spain, Sweden and UK show a decrease in the 15-64 age group.
These changes in age structure of most of the Western world can be explained from various perspectives. One of these is the impact of post WWII on life expectancies. The post-World War II (1945-1965) baby boom period is often described as “a period of demographic effervescence that affected the Western industrialised nations of the world, especially for most of those participating in World War II …” (Van Bavel and Reher, 2012, 1). It is argued that this period triggered a tremendous change in the dynamics of reproduction that saw “marriage rates accelerating, total fertility rising and the number of births increasing substantially” (Van Bavel and Reher, 2012:1). The post WWII baby boom has therefore been dramatically described as a “birth quake” with many aftershocks; “a totally unexpected, earth shattering, and ground breaking event experienced not just in the United States, but in virtually the entire Western industrialized world during the 1950s and 1960s, as birth rates erupted and the number of babies born annually in many countries nearly doubled within just a few years” (Macunovich 2002, 1).

This continued rise in the proportion of those aged 65+ received a major boost after 2010 when the baby boomer generation entered the 65+ age bracket (Eaton, 2001). It is also predicted with reference to Australia that the proportion of over 80 year olds in the next 40 years will treble, increasing from 1.7% in 2007 to 5.6% in 2047 (Western Australia Aged Care Advisory Council, 2002).

As a result, the post-WWII period put some brakes on the decades-long decline of the birth rates dating back to the nineteenth century. With reference to Australia for example, it is stated that the declining mortality rates leading to higher life expectancies and overall declining fertility rates have contributed to the overall ageing of the population (Productivity Commission, 2008).

Figure 1.3 shows projections of those aged 65 and over in New Zealand up to the year 2025. The Report estimates that the number of people aged over 85 will also increase – almost doubling from 58,000 in 2006 to 116,500 in 2026 (Grant Thornton New Zealand Ltd, 2010, p.78)
Figure 1.3: Population over 65 years in New Zealand

Source: Grant Thornton New Zealand Ltd Report (2010, 79)

New Zealand statistics estimate that in 2030, the number of people aged 65 and older will represent 35 per cent of the population and it is estimated that the over 65 population, will increase by 84% from 512,000 to 944,000 (New Zealand Auditor General’s 2009 Report). These New Zealand trends as shown in Figure 1.3 therefore mirror the demographic dynamics in other Western industrialised countries.

The changes in population age structure understandably have had major social and economic consequences. One of the most significant impacts of these changes is captured by Jacobsen, Kent, and Mather (2011, 2), who, with reference to the USA, observe that,
“The post-war baby boom … strained local hospital, public school, and postsecondary education systems, as well as the labour force as these unexpected large cohorts have moved through the life cycle”.

While increased life expectancy is accompanied by prolonged good health, there is nevertheless a rise in the numbers of the very elderly with significant care needs, and this is set to grow further in the next decades (Winter, 2006). In this respect, Cangiano, Shutes, Spencer and Leeson’s (2009) study observed that the UK population is ageing and that by 2030, the fraction of the population aged 80 years and over will rise to nearly 8 per cent, and that of the 65 years and over will rise to 36 per cent. With reference New Zealand, the Grant Thornton New Zealand Ltd report (2010,79) also suggest that

“if demographic drivers are assumed to be the only determinants of demand for aged residential care services, it is estimated that demand will increase by approximately 78% between 2008 and 2026”.

Goulding’s (2009) study on the potential impact of an ageing population on labour supply. In the USA estimated that 70% of the citizens over the age of 65 years will require some form of long term care at some point in their life.

Unfortunately the increases in the number of those aged over 65 is increasing in the backdrop of a reduced number of the young who should ideally be looking after the ageing. Hussein and Manthorpe (2005) however consider those aged above 59 as belonging to the group that needs care. For example, Figure 1.4 shows the old age and dependency ratio in eleven Western industrialised countries using this 15-59 age dimension.
Figure 1.4: Old age and dependency ratio in selected Western industrialised countries.

Source: Hussein and Manthorpe, 2005, 76 )

Figure 1.4 shows that most Western industrialised countries share comparable proportions of their population needing daily care. By 2020 it is predicted that both the proportion of the population requiring daily care and ‘dependency ratio’ will catch up and that by 2020 the dependency ratio will be highest in Japan followed by many EU countries (Hussein & Manthorpe, 2005).

The old-age dependency ratio measures the number of elderly people as a share of those of working age. It relates to the number of individuals that are likely to be “dependent” on the support of others for their daily living – youths and the elderly – to the number of those individuals who are capable of providing such support (OECD, 2011). It is normally expressed as a percentage:

<table>
<thead>
<tr>
<th>Country</th>
<th>Proportion of People Requiring Daily Care (%)</th>
<th>Dependency Ratio (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2000</td>
<td>2020</td>
</tr>
<tr>
<td>Australia</td>
<td>6.0</td>
<td>6.8</td>
</tr>
<tr>
<td>Canada</td>
<td>6.1</td>
<td>7.1</td>
</tr>
<tr>
<td>Denmark</td>
<td>6.5</td>
<td>7.4</td>
</tr>
<tr>
<td>France</td>
<td>6.5</td>
<td>7.2</td>
</tr>
<tr>
<td>Finland</td>
<td>6.5</td>
<td>7.6</td>
</tr>
<tr>
<td>Germany</td>
<td>6.9</td>
<td>7.7</td>
</tr>
<tr>
<td>Hungary</td>
<td>7.4</td>
<td>8.2</td>
</tr>
<tr>
<td>Japan</td>
<td>6.9</td>
<td>8.0</td>
</tr>
<tr>
<td>Netherlands</td>
<td>6.3</td>
<td>7.3</td>
</tr>
<tr>
<td>Spain</td>
<td>6.7</td>
<td>7.6</td>
</tr>
<tr>
<td>Sweden</td>
<td>6.7</td>
<td>7.7</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>6.5</td>
<td>7.3</td>
</tr>
<tr>
<td>USA</td>
<td>5.9</td>
<td>6.7</td>
</tr>
</tbody>
</table>

* (Total number of dependent people)/(Population aged 15-59)
### Total Dependency Ratio

\[
\text{Total Dependency Ratio} = \frac{\text{Number of people aged 0-14 + those aged 59 or 65 and over}}{\text{Number of people aged 15-64}} \times 100
\]

With reference to New Zealand, the Auditor General’s 2009 Report says that there are approximately 34,000 people living in 750 certified elderly care institutions. This then calls for an increase in the number of beds needed from 78% to 110% by 2026 to accommodate the projected increase in extra residents and to replace some of the aging facilities. In this regard, the Auditor General’s 2009 Report estimates that by 2026, between 12,000 and 20,000 extra residents will require different types of care at some stage of their lives in New Zealand. Demand for facilities is expected to grow by 20%.

#### 1.3 Changes in age structure and labour supply issues

The increase in demand for aged care facilities also mirror an increase in the demand for labour. With reference to New Zealand, it is also projected that 48,200 paid caregivers will be needed by 2036 to look after this growing number of older disabled New Zealanders requiring high levels of care and support. There are more than 42,000 people who receive care in around 700 aged residential care facilities every year (Labour Party, Green Party and Grey Power Report, 2010). The same report observes that it is very highly improbable that the local labour supply will be sufficient to meet this demand and that such shortages are unlikely to abate. Internationally, various studies (Cangiano et al., 2009; Hussein & Manthorpe, 2005; Spencer, Martin, Bourgeault, and E. O’Shea, 2010; Eaton, 2000; 2005) generally agree that the local labour market has not been able to meet the challenges resulting from the increased need for more labour due to a number of reasons. Most of the managers interviewed in these cited studies said that this recruitment difficulty was due to low wages and poor working conditions in the sector. Most studies acknowledge that it has become increasingly difficult to rely on the local labour market to sufficiently meet elderly care facilities employment demands (Cangiano et al., 2009).
It is perhaps important at this stage to capture the ‘perfect storm’ resulting from a combination of these trends as regards the provision of adequate care to the elderly requiring institutionalised care. A close analysis of the preceding issues shows that the aged care sector is increasingly coming under a lot of pressure. On one hand, statistics show that there is a sharp increase in the number of people aged 65 and above. On the other hand, there is also a marked reduction in the number of young people who ordinarily should provide care to the ageing. The dependency ratio therefore continues to grow putting a lot of pressure on the health care sector as more people seek care/support. To appreciate the intensity of the pressure on the health care system and labour supply issues, it is important to bear in mind that in most Western cultures, aged care services are mostly provided outside the family unit. Trends however show that very few young and able-bodied indigenous people find carework attractive enough. In this context, a USA study on long term careworkers conducted by Talley and Crews (2007) suggests that the shortage of local care workers is due to unattractive working conditions characterised by low pay and the performance of hard manual tasks associated with caregiving. From an employees’ perspective, caring for the elderly is generally perceived to be a relatively low skilled, low paid, low status vocation (Esplen, 2009) therefore failing to attract large numbers of job applicants. To compound the problem, the carer job is deemed largely less attractive compared to other industries such as restaurants/cafes, shops, food outlets that are also believed to be offering better wages and benefits (Martin, Elzbieta, Bump, and Breeding, 2009). The result has often been high turnover leaving employers stranded and finding it more difficult to fill up the vacancies.

With reference to New Zealand, statistics show that the increase in the ageing population has resulted in a proportionate increase in demand for institutional care of the elderly (Badkar, Demerouti & Verbeke, 2009). However, this increase in the number of the aged requiring institutionalised care has not seen a proportionate number of workers joining this industry (Badkar et al., 2009). This trend is similar to other Western countries (Eaton, 2000; Lucas and Mansfield, 2008; Spencer et al., 2007, 2010). Another significant point is that some of local workers in the New Zealand aged care industry are also ageing and require care as well (McGregor, 2012).
To exacerbate the labour supply problem are other trends that show that most households are growing smaller and becoming more geographically mobile as people move around in search for better work opportunities. It has become common for,

“households…to control risks to their economic well-being by diversifying the allocation of household resources, such as family labour... others may be sent to work in foreign labour markets where wages and employment conditions are negatively correlated or weakly correlated with those in the local area” (Massey, Arango, Hugo, Kouaouci, Pellegrino and Taylor, 1993, 436).

In many cases, this has caused the family unit to lose its capacity and capability to look after its own aged. The formal and informal aged care health systems in the Western industrialised nations have therefore suffered from acute labour shortages that have implications on quality elder care delivery. The elder care industry has had therefore to respond. How has it responded?

1.4 Coping with labour supply shortages: increased reliance on migrants

The response to the shortage of native local workers needed to fill the aged care work vacancies has been dominated by a reliance on migrant care workers. Many of the Western industrialised countries have resorted to immigration strategies, among other strategies, for international recruitment of direct careworkers (Cangiano et al., 2009; see also IOM, 2010). Research by Stone and Bryant (2011) acknowledged that the direct care workforce is increasingly becoming culturally and ethnically diverse. Stone and Bryant (2011) found that “49% of all direct care workers are white, non-Hispanic; 28% are African American; 16% are Hispanic; and 7% are part of another racial or ethnic group” (2011, 169).

A study conducted in the UK by Cangiano et al., (2009) found that within the formal system of care provision, migrants comprise around 18 per cent of all social care workers in the UK as a whole and more than half in London. In its consideration of the reasons accounting for the high shortage of suitable applicants for care jobs, the study established a clear link between migrants’ experiences of recruitment and employment in the care sector, their immigration status, the restrictions attached to it, and their pathways into, and within the social care labour market (Cangiano et al., 2009; Spencer, 2010).
Cangiano et al.,’s (2009) research on the UK considered the extent to which migrants may be needed to meet an expanding demand for care services and also examined the implications for employers, older people, their families and the migrants themselves. The findings in the UK and Australia by Cangiano et al., (2009) are to a large extent replicated in a study done by Walsh and O’Shea, (2009) in Ireland which explored the role and potential of migrant care workers and found that the proportion of migrant carers caring for Irish older people had increased significantly “over recent years, reflecting a broader global trend in care worker migration and thus, a highly competitive global market for migrant carers” (Walsh and O’shea, 2009, 1). A significant aspect of these studies is that they largely agree that care workers play an important role in providing the day to day care giving activities to people who cannot look after themselves. In this respect, in their study in the USA, Martin et al., (2009) noted that migrant workers make up more than one-fifth of the workforce that provides 80 per cent of all long-term care, although their role had been relatively unexplored. The study also acknowledged that foreigners had become critical to the delivery of care to the aged.

1.4.1 New Zealand patterns of immigration and policy perspectives

In light of the growing nature of the problem of filling up the growing list of vacancies in the low skilled economic sectors such as fruit picking, the New Zealand government introduced policies to formalise the recruitment of low skilled personnel. The Care sector labour requirements however have not really been considered officially in these polices even though New Zealand has largely relied on the employment of people from the Pacific region such as Tuvalu, Fiji, Kiribati, Samoa, Rarotonga and others, to meet the service needs for the aged Care sector. In the last six years there has been a sudden rise in migrant care workers originating from the Philippines. While in the ten years between 1991 and 2001, overseas born caregivers for the elderly roughly made up 20% of the workforce, in 2006, the proportion increased to one quarter (Badkar et al., 2009).

New Zealand’s Immigration Policy in the 1980s distinguished three main categories. The first path was that economic migrants had to have a profession which was listed in an Occupational Priority List (OPL) (Poot, 1993) and there was need for a firm job offer (Tirlin, Henderson and North (1999). The second path was the admission under the family reunification rule. The last entry pathway was on humanitarian grounds. This is still the case at the moment as noted by Badkar et al., (2009); the focus of the immigration’s residence
programme is still on migrants who are skilled and fit the skilled category to be able to contribute to the country’s economic development and productivity.

As a result of the 1986 Review of Immigration Policy, migrants were allowed to enter New Zealand if they met specific requirements like education, business, professional, age and assets (Bellamy 2008). In the 1990s there was an attempt to remove the OPL system and replace it with the point system. The New Target Net Inflow was introduced as an assessment tool to encourage immigration (Poot, 1993). The 1986 statistics show that three quarters of the migrants came from six countries: England with the largest number at 40.9%; Australia: 9.7%, Scotland: 7.9%; Samoa: 7.0%; Netherlands: 5% and lastly the Cook Island with 3.2% (Poot, 1993).

The Skilled Migrant Category was then introduced in December 2003 to replace the General Skilled Category as a means to ensure that skills are better matched to the areas with labour shortages in the country. This is a system with points allocated for skilled employment, qualifications and work experience in a future growth area which will demand employees and the local workforce will not be in the position to provide. A closer look at the criteria used to assess the immigrants’ applications shows that there are limited opportunities for low skilled migrant workers to enter New Zealand.

The 2002 Pacific Access Category (PAC) was established as a way of providing opportunities to people from Pacific region countries such as Tuvalu, Tonga, Samoa and Kiribati to enter New Zealand permanently if they meet certain requirements like health, age and English language skills as well as a job offer (Badkar et al., 2009). The Recognised Seasonal Employer scheme which was launched in 2007 is a temporary entry scheme which gives priority to migrants from the Pacific to come and work in horticulture and viticulture where the local people are not available (Badkar et al., 2009). Therefore given the situation in New Zealand, the majority of migrants are people that are highly skilled to perform other jobs, which they unfortunately rarely get when they arrive in New Zealand. It is also important to note that despite the growing reliance on migrant carers, presently, there is no formal immigration scheme specifically for migrant careworkers in New Zealand.

It is perhaps in this respect that McKinley (2009) considers migration as one of the most defining issues of the 21st century. In this respect, most studies that have explored various issues emanating from this increase in the employment of migrants (e.g., Browne & Braun,
2008; Cangiano et al., 2009; Lutz, 2002; Redfoot & Houser, 2005; Ungerson, 2004) agree that the concept of immigration and the experience of migrant workers are complex (see also Baum, 2012).

It is important therefore to provide some brief insights into the migration phenomenon.

1.5 Insights into the migration phenomenon

The 2006 United Nations Report noted that Europe has the largest number of migrant workers (64 million), followed by Asia which has 53 million, and North America, with 45 million. The report notes that these figures do not include undocumented migrants, and estimated that this latter group probably number a further 30 to 40 million worldwide (World Health Organisation, 2003).

The complex issues underpinning migration and migrant worker’s experiences are concisely captured in the following ILO statement:

Labour migration today is characterized by diversity in origin and destination situations, and in the forms, statuses, directions and durations of the migration experience… Migration for seasonal work, skilled migration, student migration, women migrating on their own for employment, forced migration (as a result of armed conflict, persecution or environmental disasters), and migration in irregular situations through trafficking and other means are all becoming increasingly prominent elements of the picture (ILO, 2010,210)

It can be argued therefore that the fundamental reasons for migration in general are diverse and highly complex. To this end, many studies generally agree that these manifold reasons range from individual, to household, to macro-structural factors (Timonen & Doyle, 2010; Portes & Böröcz, 1989). In this respect, these same studies argue that the motives behind migration are difficult to isolate although they can safely be explained from diverse socio-economic, environmental and political perspectives such as the desire for material gains, general improvement of standards of living, escaping adverse conditions in the home country, the desire to realise one’s professional and empowerment goals or the need to join social networks already established in the destination (Portes & Böröcz, 1989; Timonen & Doyle, 2010).
Due to the complex nature of the forces behind migration, it is often difficult to classify immigrants. However, Castles (2000) attempted to classify migrants and emerged with the following categories:

- Temporary labour migrants or guest-workers or overseas contract workers: this group consists of people who migrate for a limited period in order to take up employment and remit their earnings back home.

- Highly skilled and business migrants: this group is made up of people who are highly qualified such as managers, executives, professionals, technicians. This group is usually sought after by many countries.

- Family members: this group is also known as family reunion or family reunification migrants. They migrate to join family members who would have already entered an immigration country under one of the above categories.

- Irregular migrants: This group consists of mainly undocumented or “illegal migrants.

- Refugees: according to the 1951 United Nations Convention relating to the Status of Refugees (Assembly, U.G., 1951), a refugee is a person residing outside his or her country of nationality, who is unable or unwilling to return because of a ‘well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion’.

- Asylum-seekers: people who move across borders in search of protection, but who may not fulfil the strict criteria laid down by the 1951 United Nations Convention

- Forced migration: in a broader sense, this includes not only refugees and asylum seekers but also people forced to move by environmental catastrophes or development projects (such as new factories, roads or dams).

- Return migrants: people who return to their countries of origin after a period in another country (Baum, 2012; Castles, 2000).

These categories reflect that there are diverse push, pull, and network factors that interact to create a highly volatile and mobile global community (Baum, 2012).
Castle’s (2000) attempt to profile migrants is significant for a number of reasons. The profiling reflects that migration is largely constituted by a diversity in terms of people, country of origin, culture and language all which make migrants distinctly different from the citizens of the receiving country. The profiling also reinforces the idea that most migrants are pushed out of their home environments to seek a better life elsewhere. This is interesting especially when considered from the perspective of the nature of carework which some of them take up when they arrive in a foreign country. (Please see Chapter 2 for a detailed discussion on this subject in relation to how these diverse pull and push factors that characterise migrants might be implicated in the manner in which migrant carers deliver care).

Having moved from their home country, for whatever reason, migrants sometimes find themselves operating in an environment that has many racial stereotypes (Williams and Gavanas, 2008). These racialised stereotypes operate differently as hierarchies in different countries. For example, Williams and Gavanas (2008) notes that in the UK, some employers consider Latin Americans more loving and Eastern Europeans more hard working, while Australians are seen as cheerful and flexible. In the same vein, Lister et al.,’s (2007) research discovered that in Spain, Latin Americans are considered slow, whilst Moroccans are deemed untrustworthy. In Europe, the Philippines are often most preferred as carers whilst in France, black African workers are considered ‘dirty’ (Narula, 1999). The Parisians are also said to favour employment of Haitian women (Anderson, 2000). In the context of careworkers specifically, Williams (2010, 386) contends that “Such hierarchies point to a complex interrelationship between the gendered gradations of care work with colonial histories, past and contemporary religious antagonisms and essentialist stereotypes based on gender, nationality and ethnicity”.

The prevalence of such stereotypes and other unpleasant conditions in the foreign country explain why Walsh and O’Shea, (2009) argue that given a choice, most people would prefer to stay in their home bases. It could be argued that migrants that are pushed out of their home countries because of different hostilities, such as war, fear of persecution on account of race, religious intolerance, or other difficult conditions, the decision to join the Care sector might not necessarily be by design. While they may have professional qualifications in their home countries, in their new homes they simply have no choice but to take up work as careworkers in order to earn a living.
From a research perspective, a significant question needing attention therefore is: What could be the implications from a management perspective, of employing migrants vis-à-vis the desire to ensure quality care delivery to the aged patients? In short, do managers perceive any merit in the idea of treating migrant workers as a unique group of workers with unique challenges that require unique management interventions in order to ensure their ability and commitment to the delivery of high quality aged care?

1.6 Profiling the New Zealand aged Care sector

It is reported that New Zealand has one of the highest proportions of people in residential care in the Western industrialised world and is relatively unique in its continued focus and support of residential care facilities for the aged (Grant Thornton New Zealand Ltd, 2010, 86). New Zealand policy statements are increasingly advocating for the concept of ‘ageing in place’ in which older people are encouraged and assisted to remain in their own homes, rather than moving into aged residential care in order to enhance their sense of independence and self-reliance (Davey, 2006).

Notwithstanding these policy pronouncements, the Grant Thornton New Zealand Ltd (2010) Review also says that a lot of the aged people are cared for in aged care institutions. The report says that approximately two thirds (68%) of New Zealand’s aged residential care facilities are controlled by Not For Profit operators and 32% are owned by For Profit organisations.
The Grant Thornton New Zealand Ltd (2010) divided the aged care facilities into two broad groups. These are ‘For Profit’ (32%) and ‘Not For Profit’ (68%) as illustrated in Figure 1.5. Many of these facilities are owned by major multinational companies. Fifty-eight of these facilities are owned by Oceania Care Group (owned by Australia based Macquarie Bank. Forty-five facilities are run by Bupa Care Services (owned by Bupa UK), 22 facilities are owned by Radius Residential Care (Kuwait Finance House), 21 owned by Ryman Healthcare (Garlow Management (Canada) and Ngai Tahu Capital), 17 owned by Metlifecare (JP Morgan Nominees, FKP, and Macquarie Investment Holdings, 16 for Ultimate Care Group and 12 for Summerset Care (Labour, Green Parties and Grey Power Report, 2010, 18). With regards to the Not-for-profit sector, the main players are Presbyterian Support, responsible for 33 facilities and the Selwyn Foundation and Christian Healthcare Trust which have eight facilities each (Labour, Green Parties and Grey Power Report, 2010, 18).
1.6.1 Types of care facilities

However, aged care facilities can also be described using other dimensions such as levels of care. There are different types of care levels that are classified under the elderly care institutions. The type of licence determines the type of service available. In this respect, there are four broad categories of elderly care organisations, based on the level or intensity of care provided. These are 1: Independent living communities; 2: Assisted living facilities; 3: Nursing homes; and 4: Organisations with a mix of these services (Madas and North, 2000).

1. Independent Living (Retirement Community): these focus on the independency of the resident and allowing them to enjoy retirement without worrying about the daily responsibilities of owning a home. These residents are usually very independent, that means they are still healthy and active. Retirement villages are generally for the relatively well off, and people with low incomes are generally unable to access these options. The Grant Thornton New Zealand Ltd Report (2010) says that 37 % of rest homes are co-located with retirement villages.

2. Assisted Living Facilities: these are also known as Rest Homes and are for residents who are unable to live without some form of assistance but are not yet assessed for nursing home care. They provide a higher level of service for the elderly which include preparing meals, housekeeping, medication assistance, laundry, and also regular check-in’s on the residents. They are designed to bridge the gap between independent living and nursing home facilities.

3. Respite Care: this is usually offered by assisted living facilities. This aid is offered only on a temporary basis, for instance when the family decides to go on holiday and they leave their elderly in rest home where there is available help. Respite care allows the primary care giver or family member relief for a few days or even just a few hours. There is also another type known as the ‘Traditional nursing home’. This type of nursing home is used only for a short term to help an individual be rehabilitated from a crisis, such as a fall or a stroke, until they are able to return to their previous living situation. This can be under assisted living facilities or nursing homes depending on the level of independency of the resident. Other times, residents require long term medical care with this level of support.

4. Nursing Home: This term is used to describe a facility that offer 24 hour nursing care services for the residents. These are suitable for the residents that the family do not feel are safe to be at home on their own. These residents may need 24hours medical care. Nursing
homes have registered nurses who provide medically supervised care to residents that typically are either disabled or chronically ill (Madas & North, 2000).

5. Mixed services care facilities: Madas and North (2000) describe these as care facilities that apply for a licence to provide different types of aged care services. These may be in a particular type of service or a combination of services such as rest home and progressing hospital care plus dementia. Some facilities also provide other types of sheltered care, for example retirement villages and independent units in addition to the rest home and hospital level services. The level and type of services reflect the level of care needed by aged patients as assessed by an independent agency contracted by the Health Funding Authority (Madas & North, 2000).

However, recently there has been a new development in the Care sector: the Eden Alternative. This model of care has just begun to be established in New Zealand and it is reported that nine facilities are practicing it. The Eden Alternative is based on normalising everyday living and incorporating a community spirit by addressing the plagues of loneliness, helplessness and boredom. It encourages the creation of interactive and vibrant care environments placing less emphasis on structured regimes, and giving residents contact with plants, animals, children and the local community (Miller, Booth and Mor, 2008).

1.7 Some emerging questions for academic inquiry

The preceding paragraphs have established that immigration and the experiences of migrant workers in general are very complex issues (Baum, 2012). Migration has brought diversity to the employment profile of many organisations raising questions about the implications of their employment especially from the viewpoint of management’s desire to ensure quality care delivery. To this end, Dilworth-Anderson and Palmer (2011) capture the problem of ensuring delivery of quality care to the aged patients when they observe that,

Older adults come in contact with the health care system at various entry points and usually maintain this contact with the system for an extended time. It is not surprising, then, that in a system currently plagued with service delivery gaps, poor communication, and responsibility shifting, many older adults become lost in a maze of discontinuity (2011,9).

The participation of managers in making sure that migrants do not worsen these problems is
therefore central to this study. The question emerging in light of the many internationals being employed as careworkers due to migration, relates to: ‘What processes have to be developed to prevent such confusion among patients and their caregivers as a way of improving the quality of care and life for older adults’? An investigation of the perceptions of management about the challenges such diverse migrants bring to the management of aged care facilities promises therefore to emerge with findings that may enrich our understanding of management’s coping strategies to ensure uncompromised quality care delivery.

This study’s major concerns have also to be understood from the viewpoint of extant studies on the aged care sector of New Zealand. For example, The Grant Thornton New Zealand Ltd Report (2010) that was commissioned by New Zealand District Health Boards (DHBs) notes that because of increased demand, the workforce employed in the aged residential care sector has doubled in the last 20 years to 33,000. The Grant Thornton New Zealand Ltd Report (2010, 109) compares the New Zealand European proportion of aged care residents – 85 percent– with that of residential care employees – 56 percent. The latter compares to 68 percent European in the NZNO survey of carers (Walker, 2009) and 77.8 percent from 2006 Census data (Badkar, 2009, 30). Māori and Pacific Islanders each comprise 10 percent of the residential aged care workforce (The Grant Thornton New Zealand Ltd Report, 2010). The report noted also that workers of Asian ethnicity are a growing proportion of the workforce and says that between 2001 and 2006, their proportion rose from 3 percent to 7 percent, while the Māori and Pacific Island shares remained constant (The Grant Thornton New Zealand Report, 2010).

Although the report claims that its “review of aged residential care services in New Zealand is the most extensive ever undertaken and had the highest provider participation rate of any comparable international study”, it, however, does not explore the implications to quality care delivery emanating from this diverse composition of this workforce.

Similarly, another 2010 study entitled “A Report into Aged Care What does the future hold for older New Zealanders” that was commissioned by the Labour Party, Green Party and Grey Power to investigate New Zealand’s rest homes and home support services, identified the following issues as needing attention: residents; the residential age care facilities; the workforce; the auditing process; home based support services; and family carers. This very interesting report however, fleetingly addresses the issue of migrants who work as carers. The study does not delve deeply into issues to do with quality care delivery in relation to the
participation of migrants.

In the same vein, Badker et al.,’s (2009) study, although making some valuable contribution to an enriched understanding of the aged care sector in New Zealand and migrant participation, still does not focus much on the implications of a multicultural service delivery environment to the quality of care delivered. The report however made some very significant observations that the migrant carers are in most cases manipulated by the agencies that they work for and sometimes they work as many as 160 hours a fortnight, in order to repay the agents their initial costs.

Perhaps the most comprehensive study to date about the New Zealand Aged Care sector in relation to the increased participation of migrants as carers is the Human Rights Commission Report compiled by Judith McGregor (2012). McGregor (2012) highlighted the growing reliance on migrant care workers in the Aged Care sector, looked issues to do with the need for more beds for the elderly and also an increase in the numbers of care workers. McGregor’s (2012) research identified ten crucial aged care sector elements. These are “respect and value, workforce supply, recruitment and retention, conditions of work, wages and parity, staff to resident ratios, training and qualifications, managerial competencies, men as carers, migrant workforce and regulatory frameworks as shown in Figure 1.6 below:
Figure 1.6: Range of migrant careworker issues explored by McGregor

McGregor (2012, 15)

McGregor’s (2012) did a sterling job in exposing the challenges faced by migrant workers from the perspective of the employees themselves. However, as comprehensive as McGregor’s (2012) study is, it does not report in detail on the implications of employing migrant carers to the delivery of quality of care, nor does the report explore strategies managers can implement to deal with migrant careworkers’ challenges. McGregor’s, (2012) as well as Badker et al.,’s (2009) studies also do not adequately capture the service relationship aspect of carework such as the emotional labour associated with the provision of care. McGregor’s study is more focussed on the examination of Equal Employment Opportunity issues, among others, that are related to the Aged Care sector in New Zealand. Most of the studies therefore give fleeting attention to the concept of intercultural service relationships and its impact on the delivery of care.

It can therefore be argued that most extant studies have not provided, in a detailed fashion the perspective of managers to the employment of migrants as carers although it is the managers
who, on a day to day, work with these migrants and whose duty it is to make sure that the migrant carers deliver the expected levels of quality care to the elderly patients.

The Human Rights Commissioner Report by McGregor (2012) provides the viewpoint of both care workers and management of aged care facilities, and perhaps here-in lays one of the issues that need further academic exploration. Whilst a report that provides both perspectives is very welcome, it runs the risk of giving at once, perfunctory attention to some important issues, and robust attention to others. In this regard, it can be argued that the study did not explore in detail the management implications of employing migrant carers especially in regard to the desire to provide quality care to the elderly.

It can also be argued that, it is one thing to present a problem from the perspective of the person experiencing challenges, and certainly another, to present it from the perspective of the person who ordinarily is expected to institute mechanisms to ameliorate the challenges. It can also be argued that in this context, the view of the managers about the challenges migrant carers encounter is critical to their successful resolution. It may also be argued that if managers do not share the same views about the challenges or their intensity and significance, they may not be expected to do something about a problem they deem ‘non-existent’.

Another point to note is that the Human Rights Commission Report by McGregor (2012) paid more emphasis on the North Island, understandably because that is where there are higher levels of migrant settlement. It is important therefore to investigate what the situation is like in the Southern regions that have lower migrant settlement and whether the issues are felt keenly as they are in the Northern regions of New Zealand. There is therefore a gap that needs to be addressed in terms of the scope of the study and issues in question.

It is this context that, in order to provide depth to the exploration of the phenomenon of migrants’ participation in aged care delivery in New Zealand, this study focuses on aged care facilities within a small area: Dunedin a city, located in the South Island. In 2010 the estimates from Statistics New Zealand provisionally put Dunedin’s population at 124,800 (New Zealand Statistics 2006). Figure 1.7 below provides a graphic representation of population age structure changes since 1981 and projections to 2026.
Figure 1.7: Estimated resident population

Source: Statistics New Zealand, 2006,16

1.8 Structure of the study

By way of progress this study is organised into eight chapters. Chapter 2 reviews literature about the concept of ‘care’. Care like all other services, is a fragile concept that can easily be compromised if the provider does not put his/her heart into the work. In order to appreciate the cumulative possible impacts on the employees of the care working environment, in which ‘care’ is an integral component, this chapter analyses the intercultural nature of service relationships. The literature reviewed here prompts questions about how managers can incorporate the intercultural nature of service encounters and service relationships that characterise quality care delivery in their efforts to deliver quality care.

Chapter 3 reviews literature on profile of migrant workers. It will focus on the challenges they bring to work and also those that they meet at their work places. The chapter also explores the challenges experienced by migrant care workers in relation to racism, discrimination, immigration and visas and also experiences which have implications on how the managers manage this workforce. In light of the literature perspectives on the challenges experienced by migrant carers elsewhere, the review of related literature in Chapter 3 prompts questions
about the implications of such migrant carers’ challenges in the New Zealand, Dunedin City context to the delivery of quality care.

Chapter 4 presents Human Resource Management (HRM) as a conceptual framework through which the nature of challenges that are faced by managers of migrant carers, and possible solutions can be appreciated. The chapter develops the argument that since aged care facilities operate like any other ‘For- Profit organisation, the innovative application of HRM strategies to achieve a competitive edge should be a concern for these facilities. Since this process is embedded in people, many of the necessary capabilities that the aged care sector facilities require are closely linked to HRM strategies and practice.

Chapter 5 follows with an elaborate discussion of the qualitative research design and the merits of its adoption to achieve the objectives of the study. The chapter spells out the ontological premises of the study in which the exploration of the perceptions of managers, regarding the employment of migrant carers, is approached from within the constructivist paradigm or the interpretivist framework of inquiry. This framework supports the study’s ontological perspective to the effect that there exists not just one, but multiple realities that are constructed and can be altered by the knower. The in-depth interview technique that was largely used to collect relevant data is also explained from this interpretivist ontological perspective.

Chapter 6 and Chapter 7 contain the findings and analyses of the same. This chapter shows that managers have a generally shared view of the implications of the increased participation of migrants as carers. Most of the managers identified perceive racism, cultural differences and perceived discrimination, as well as English proficiency, as some of the challenges the migrants encounter at work. Although there wasn’t a shared view regarding the exact implications of these issues to the delivery of quality care, most managers expressed the view that they believed such issues could, and were, impacting on service quality delivery.

Chapter 8 concludes the discussion and provides some recommendations that may be considered by various stakeholders to improve the management of aged care facilities in relation to the desire to ensure quality care delivery. The chapter recommends, among many other recommendations, that the managers’ skills can be enhanced by some form of formal diversity training on their part. The study ends by recommending that further studies be undertaken to investigate these issues from the viewpoint of migrant carers themselves.
Chapter 2: Cultural diversity and service encounter management

2.1 Introduction

One of the most challenging issues with regards to care delivery is, paradoxically, the concept of care itself. Like all other services, care is a largely fragile intangible concept whose quality depends largely on the behaviour patterns of the carer and the cared for. Its delivery can therefore be easily compromised if the provider and the receiver do not have a shared understanding of what constitutes quality care. The largely intangible dimension of care has made it such an elusive concept with repercussions on how it is conceptualised, delivered and judged by those who provide, and receive it. In order to appreciate the dynamics of aged care delivery in an increasingly multicultural service environment, this chapter explores the concept of carework from the perspective of intercultural service relationships and/or service encounters. The chapter explores literature perspectives on the concept of care and how the aged patients characterise quality care, characterisations of quality care in relation to the participation of migrants as carers, and their implications to the management of intercultural service relationships. Characterisations of care jobs are explored as well in which care jobs are reflected as having huge potentials to cause occupational stress. Literature perspectives on the strategies that employees generally adopt in dealing with stressful job conditions and job tasks are also reviewed. The workers’ stress coping strategies are considered from the viewpoint of behaviour patterns that are consistent with quality care as it is defined by the elderly patients. Overall, the literature prompts questions about what managers can do to create mutually beneficial care-provider and care-receiver relationships that happen in an intercultural environmental context due to the increased participation of migrants in the delivery of care.

2.2 The concept of care

Most of the studies conceptualise care work as ‘nurturant work’ (England, 1992) or ‘interactive service work’ (Leidner, 1993) that provides a face-to-face service aimed at developing the capabilities of the recipients (England, Budig & Folbre, 2002) and places a lot of ‘psychological or emotional’ (Peeters & Le Blanc, 2001) demands on the carer. This is primarily because in most cases, the wellbeing of the elderly is entirely reliant on the carer. In this regard Fujisawa & Colombo (2009) characterise carework as involving the provision of care to people that have a reduced degree of functional capacity, physical or cognitive, and are
consequently dependent for an extended period of time on help with basic activities of daily living such as bathing, dressing, eating, getting in and out of bed or chair, moving around and using the bathroom.

The activities that are performed by carers such as lifting, bathing, feeding and cleaning the aged patients are said to have a very big likelihood, in the long term, of causing serious health repercussions for the care provider such as neck, shoulder or back problems (Peeters & Le Blanc, 2001). It is generally agreed that the work of direct care workers as “eyes and ears” of the care system, in the provision of intimate and personal hands-on care, supervision, and emotional support to the aged is complex and frequently both physically and emotionally challenging (Stone, 2004).

Another critical dimension of carework is therefore its emotional dimension; suffice to mention that this is a quality it shares with other professions such as nursing, teaching and other social services. For example, it is argued that “caring labour is a form of emotional labour because it requires both the emotion of caring about, and the activity of caring for another person” (Himmelweit, 1999, 36). Emotional work is also defined as labour involved in “dealing with other people’s feelings” (James 1989, 21). On the other hand, Hochschild defines emotional labour as the “management of feeling to create a publicly observable facial and bodily display” (1983, 7). This latter definition acknowledges that the effort of management over one’s own feelings will usually be made in order to create a desired emotional state in others.

When applied to carework, this would imply that caring work is effectively measured by its consequences on others. In this regard, Himmelweit (1999) argues that because caring involves two aspects: ‘motivation to care’, and ‘the activity of caring’, it requires that the worker who provides it has a caring motivation, and acts in a way that transmits to the caree the experience of being cared for, in both emotional and physical senses. Himmelweit (1999) makes the important point that these two dimensions require effort on the part of the carer. In some situations the emotional labour done is of a transient nature in which the interaction with any particular person is limited in time. However, it can be argued that carework is defined by the creation of long term service relationships. The investment of emotional labour is therefore understandably more considerable. In this regard Himmelweit (1999) further makes a very insightful observation by arguing that:
Caring…specifically involves the development of a relationship, not the emotional servicing of people who remain strangers. This is why paid carers are usually allocated on a continuing basis to particular cares and often show a marked preference for maintaining such relationships, even in the face of some personal inconvenience (1999,35).

These views are reinforced by research in frontline nursing home carework which showed that the emotional labour required is not simply the ‘display’ of a felt state, such as kindness, compassion, and cheer, but an ability to behave and complete tasks patiently, gently and with tolerance, even if one is being physically or verbally attacked or insulted (Eaton, 2000). These findings suggest that the ‘soft’ dimensions of care are more important than the technical aspects of care delivery.

2.2.1 Quality care perspectives

Many studies perceive quality care as multifaceted, requiring to be approached from at least four angles. The first one is the conceptualisation of quality in health care from a ‘patient-centred’ perspective (Aller & Coeling, 1995; Bowers, 2001, Lutz & Bowers, 2000; Mattiasson & Andersson, 1997). This approach relies on the patients themselves to assess the quality of care they receive. Predictably, there is controversy regarding the ability of consumers of health care to define and assess especially the technical dimensions of quality care.

The second approach considers the degree of autonomy as reflected in the patients’ active participation as key to the definition of quality (Jirovec & Maxwell, 1993; Mitchell & Koch, 1997). In this case, the patients’ perceptions of choice determine quality (Brooke & Short, 1996). In this context, a study conducted in the USA by the National Citizens’ Coalition for Nursing Home Reform (1985,15) found that most residents defined quality care as having “choices and the ability to make them” in a happy, safe environment, being treated as individuals, and being allowed to be independent. The third approach uses ethnography to examine how good or bad the experience of being a patient in a given resident institution (Clark & Bowling, 1990). The fourth approach conceptualizes quality care as care that meets the expectations of those who purchase it (Bowers, 2001; Lengnick-Hall & Barton, 1995). This approach puts a lot of weight on the measurement of consumer satisfaction (Jackson & Kroenke, 1997; Laitinen, 1994). This differs from the patient-centred approach, in that those
who purchase care may not be the consumers of care. For example, family relations purchase care on behalf of their aged, but they may not be the ultimate consumers of that care.

An interesting conceptualisation of quality care from the perspective of this study’s focus on migrant carers’ behaviour, is the one that places a lot of weight on social relationships (Grant, Reimer & Bannatyne 1996; Mattiasson & Andersson, 1997). In this context it is argued that the human relationship between older people and their direct care workers is the most, if not the defining feature of long-term care (Hussein and Manthorpe, 2005, 83).

In this respect, Lim, Tang & Jackson (1999) defined care by dividing it into two dimensions. The first category is technical aspects: the competence of the health care provider, thoroughness, clinical and operating skills. The technical aspects or dimensions of ‘care’ can be measured objectively to a certain extent. The second characteristic is defined by the interpersonal dimension: the humane, socio-psychological qualitative aspects such as courtesy, and warmth, approachability that define the relationships between patient and health care provider (Perucca, 2001). These two dimensions of care reflect care as comprising tangible and intangible aspects.

Other studies have also defined care in the following manner as captured in Figure 2.1:

![Figure 2.1: Examples of dimensions of quality of care.](source: Campbell, Roland, and Buetow, (2000, 1615))

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<tr>
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<tr>
<td>Accessibility</td>
<td>Accessibility</td>
<td>Effectiveness</td>
<td>Accessibility</td>
</tr>
<tr>
<td>Patient-centredness</td>
<td></td>
<td>Efficiency</td>
<td>Patient perspectives</td>
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<tr>
<td>Effectiveness</td>
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<tr>
<td>Efficiency</td>
<td>Efficiency</td>
<td>Acceptability</td>
<td>Efficiency</td>
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<tr>
<td>Continuity/co-ordination</td>
<td></td>
<td>Equity</td>
<td>Continuity</td>
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<tr>
<td>Acceptability</td>
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<td>Legitimacy</td>
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<td>Relevance</td>
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</table>

Figure 2.1: Examples of dimensions of quality of care.
The dimensions used to define care in Figure 2.1 suggest that the patients’ perspective is integral to the process of care delivery. For example, the variables listed in Table 2.1 such as ‘patient perspectives’, ‘acceptability’ ‘efficiency’ ‘effectiveness’, ‘legitimacy’ can only be judged from the viewpoint of the care receivers and not care providers.

These observations are also echoed in other studies that found that interpersonal elements that influence health care are eye contact; attitude; being able to ‘tune out the world and tune in the patient’; and non-verbal gestures, body language and facial expressions (Perucca, 2001). Staff attitudes; sensitivity; responsiveness; sincerity and trust are critical to the wellbeing of the patients (Perucca, 2001). In the same vein Donabedian (1980) views patients’ perspectives of quality in healthcare as based on the ‘processes of care’ that is, how care is delivered. Many studies on long-term care (LTC) have therefore used consumer perspectives to, not only define quality, but to determine the weight of these dimension of quality (Grant et al., 1996; Mattiasson & Andersson, 1997).

The 1985 the National Citizens’ Coalition on Nursing Home Reform (NCCNHR) held multiple discussion groups in the USA with 457 residents from 107 nursing homes in 15 cities to explore a consumer perspective on nursing home quality. Research has shown that generally health care customers expect their carers to exhibit, among others, the skills of competence, such as skilful and timely medication administration knowledge, honesty, listening skills, availability and professional attitude (Perucca, 2001). The NCCNHR (1985) study found that the residents rarely identified clinical care as the most important factor in their quality of care or life. Very few of the interviewed aged patients made reference to ‘technical skills’ or basic health knowledge, medical skills, or expertise in operating appropriate equipment, such as a hoist. Instead, the elderly participants of this study reported that pleasant and positive relationships and feelings, and attitudes between staff and residents are crucial to quality of life and care (NCCNHR 1985). Individualised care ranked high with most elderly patients (NCCNHR 1985, I-15).

Interestingly, most of these dimensions that residents use to define quality care can also be captured in Parasuraman, Zeithaml and Berry’s (1985) model of service quality and customer satisfaction. In their discussion of service quality Parasuraman et al., (1985) identify reliability, responsiveness, assurance, communication, credibility, security, competence, courtesy, understanding the customer, and access as critical determinates of service quality. Reliability is the ability to perform the promised service dependably and accurately, whilst
responsiveness is about the willingness to help customers and provide prompt service. Assurance refers to the knowledge and courtesy of employees and their ability to inspire trust and confidence. Finally, empathy is a reference to caring, individual attention the firm provides its customers (Parasuraman, Zeithaml & Berry 1988, 23). These dimensions mainly focus on the human aspects of service delivery (responsiveness, reliability, assurance, and empathy) and the tangibles of service. They also seem significant dimensions of what a well-managed aged care facility would be most concerned about.

A brief application of Parasuraman et al.’s (1985) conceptualisation of service from the perspective of quality of care delivered by migrant workers and all other carers, reveals the critical importance of the attributes of responsiveness, assurance and empathy. Figure 2.2 makes an attempt to adapt this model to the care giving sector basing the service quality measurement items on existent research that has shown that elderly patients value more the humane, and not necessarily the technical dimensions of health care delivery. Figure 2.2 makes an attempt to capture some of the tangible and intangible dimension which may impinge on how carers deliver quality in relation to the perceptions of those who receive it.
<table>
<thead>
<tr>
<th><strong>TANGIBLES</strong></th>
<th><strong>INTANGIBLES</strong></th>
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<tbody>
<tr>
<td>Quality of hoist machines</td>
<td>Carers’ responsiveness dimension</td>
</tr>
<tr>
<td>Quality of beds</td>
<td>• The willingness or readiness of employees to provide the service</td>
</tr>
<tr>
<td>Quality of food</td>
<td>• Prompt willing service</td>
</tr>
<tr>
<td>Appearance of dining utensils</td>
<td>• Appear available to help</td>
</tr>
<tr>
<td>Quality and feel of the dining room furnishings</td>
<td>• Good eye contact</td>
</tr>
<tr>
<td>Quality of bedding material</td>
<td>• Polite facile expressions</td>
</tr>
<tr>
<td>Appearance of carers: do they look professional (in uniforms or not)</td>
<td>• Sincere interest in problem-solving</td>
</tr>
<tr>
<td>Appearance of buildings (wall paintings, landscaping)</td>
<td>• Provision of adequate information about the service delivered</td>
</tr>
<tr>
<td>Appearance of recreational activities vans/vehicles</td>
<td>• Prompt response to patients’ requests</td>
</tr>
<tr>
<td>Quality of lawns: landscaping issues</td>
<td>• Willingness to help patients</td>
</tr>
<tr>
<td>Quality of seats in the cars</td>
<td>• Delivering services on time</td>
</tr>
<tr>
<td>Appearance of carers: do they look professional (in uniforms or not)</td>
<td>• Keeping promises</td>
</tr>
<tr>
<td>Appearance of buildings (wall paintings, landscaping)</td>
<td>• Providing error-free service</td>
</tr>
<tr>
<td>Quality of lawns: landscaping issues</td>
<td>Carers’ assurance and confidence dimension</td>
</tr>
<tr>
<td>Appearance of recreational activities vans/vehicles</td>
<td>The knowledge and courtesy of employees and their ability to convey trust and confidentiality</td>
</tr>
<tr>
<td>Quality of seats in the cars</td>
<td>• Being served by the appropriate personnel;</td>
</tr>
<tr>
<td>Appearance of carers: do they look professional (in uniforms or not)</td>
<td>• Ability to act in a manner that reinforces elderly</td>
</tr>
<tr>
<td>Appearance of buildings (wall paintings, landscaping)</td>
<td>• Patients’ confidence</td>
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<tr>
<td>Appearance of recreational activities vans/vehicles</td>
<td>• Experienced and competent carers</td>
</tr>
<tr>
<td>Quality of lawns: landscaping issues</td>
<td>• Fluent and understandable</td>
</tr>
<tr>
<td>Appearance of carers: do they look professional (in uniforms or not)</td>
<td>• Communication with elders</td>
</tr>
<tr>
<td>Appearance of buildings (wall paintings, landscaping)</td>
<td>Carers’ empathy and Sensitivity dimension</td>
</tr>
<tr>
<td>Appearance of recreational activities vans/vehicles</td>
<td>The provision of caring individualised attention to customers’</td>
</tr>
<tr>
<td>Quality of lawns: landscaping issues</td>
<td>• Recognising regular customers</td>
</tr>
<tr>
<td>Appearance of carers: do they look professional (in uniforms or not)</td>
<td>• Learning individual needs and requirements</td>
</tr>
<tr>
<td>Appearance of buildings (wall paintings, landscaping)</td>
<td>• Customised service Showing compassion pleasant, friendly personnel</td>
</tr>
<tr>
<td>Appearance of recreational activities vans/vehicles</td>
<td>• Clear understanding of specific elderly patients’ needs</td>
</tr>
<tr>
<td>Quality of lawns: landscaping issues</td>
<td>• Cultivation of friendly relationship</td>
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</tbody>
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**Figure 2.2: Contextualising Parasuraman et al.,’s (1985) service quality model**

Figure 2.2 Source: adapted from Parasuraman et al., 1985;1988
The preceding characterisations of care present the intangible dimensions of care as more important to residents than the tangibles. Whilst a carer might be an expert in operating a hoist machine, during the process of operating it, there is no cordial communication between the carer and the caree, or if the carer’s tone of voice is harsh, it is unlikely that the quality of care will be rated positively by the patients.

Since quality care is defined largely by the nature of interactions that take place between the carer and caree, this raises questions about the implications to quality care delivery arising from the increased participation of migrants as carers especially since they import their own culturally laden definitions of quality care service relationships. What could be the implications to quality care delivery if these socio-culturally defined care perspectives are not in harmony with those off the carees who, it must be added, have their own set of culturally defined quality care perspectives as well. Although these concerns apply to carework in general, it would be interesting to explore whether or not managers perceive the introduction of the ‘migrant factor variant’ as complicating further the quality care delivery equation.

2.3 Experiential qualities of care: cultural context of the elderly care service delivery relationships

The preceding discussion has made attempts to expose the dynamics of care delivery from the viewpoint of service quality dimensions that elders use to judge quality care. The significances of the dimensions captured in Figure 2.2 become more pronounced when they are considered from the perspective of the viewpoint of the participation of migrants as caregivers. Invariably most migrant workers will be learning a new service culture and quality expectations that may be different from their own, yet they are still expected to meet and exceed the clients’ expectations of what could be called ‘acceptable service levels’. This prompts questions about the level of awareness of managers about the intercultural dimensions of quality care delivery and what can be done to improve quality care delivery by migrant carers.
2.3.1 Care delivery and role of culture

In order to fully appreciate how the above dimension captured in Figure 2.2 are delivered and the challenges they may create, for managers, carers and carees, vis-à-vis quality care definition and delivery, it is important to explore the migrant carers’ involvement especially given that the migrants import into the workplace their own language, behaviours, mannerisms or culture in general. It is indeed important to consider the role of culture and how it might impact on the provision of quality care. In this regard, Dilworth-Anderson and Palmer make an insightful observation when they argue that,

“The health and wellness of older adults are shaped by their relative life experiences, core beliefs and values, and meaningful interactions. Such meaningful experiences, health related or not, are interpreted within the human sphere of one’s individual culture throughout his or her life course” (2011, 3).

Dilworth-Anderson and Palmer’s (2011) argument is that conceptualisation of care and its delivery are moderated by well-entrenched diverse cultural values and experiences. These values and beliefs might be very difficult to adjust and therefore may strain care service encounters as migrant carers provide care to the elderly patients. The cultural context in which care is provided highlights the complex environment in which migrant careworkers operate.

Goodenough (1981) says that culture is reflected in an individual’s beliefs and behaviours, including the thoughts that exist inside a person’s mind. Culture is what is learned, the things one needs to know to meet the standards of others and consists of the criteria or guidelines for speaking, doing, interpreting, and evaluating others (Goodenough, 1999). Culture can also be viewed as the totality of behavioural norms and patterns that are shared together by a social group (Usunier, 1996). It can be argued that culture defines how people think about themselves and how they interact with one another. This is an especially useful argument when considered form the viewpoint of the increased participation of migrants as carers since they also bring their cultures which may conflict with that of the people they serve, be they managers, family relations of patients, or patients themselves.

For example, Dilworth-Anderson and Palmer (2011) have observed that many racial and ethnic groups have major cultural influences that affect their health behaviours, perceptions about health, and ways in which they may or may not address health problems. In this regard
it has been observed that language and familiar cultural settings affect the way adults perceive their health (Heyman and Gutheil, 2010).

The elderly patients share diverse cultural backgrounds and the migrant workers share diverse cultural beliefs as well. The delivery of, especially the intangible dimensions of aged care quality as highlighted in Table 2.1 has to be conceptualised in this context of the existence of several cultures within one work place. To this end, another important question that emerges relates to how culture impacts on the inter-cultural care relationships that exist for migrant care-workers and their native care-receivers. Questions may also be raised about the management’s appreciation of the inherent difficulties emanating from the elusiveness of the concept of quality care and in relation to its intersections with characteristics of migrant careworkers who invariably might not be in those jobs out of their own volition. (See Chapter three on the subject of migration and how some migrants find themselves as careworkers).

2.3.2 Cultural context of quality care provision: services encounter management

The previous sections have established that health services are differentiated from other professional services by the intimate relationship that exists between the customer and the health care provider (Perucca, 2001). The creation of conditions that are conducive to the creation of these intimate relationships or the creation of quality interactions between the patients and the migrant carers, indicate the integral role that managers have to play. The creation of such conditions does not appear easy especially when considered from the viewpoint of the migrants. Bourgeault, Atanackovic, Rashid, and Parpia (2010) argue that the relationship between older adults and care workers become more complicated when care workers are immigrants, particularly those who are visibly different or belong to racial minorities. In this regard the differences in culture tend to make it difficult for the elderly and the migrant to create a relationship that is defined more by equity than ‘master servant relationship’.

There is also the issue of acceptance on the part of the carees to be attended to by migrant carers. For example, it is argued that “The acceptance of migrant carers by older people is an important factor in ensuring an effective caring relationship and thus influences the quality and standard of care that is received” (Walsh and O’Shea, 2009, 101). Acceptance is partly influenced by the cultural tenets and values of both the interacting elements: the carer, the caree, caree’s family relations, and the managers - in varying degrees perhaps.
Cultural values and assumptions about life, styles of social interactions, behavioural norms, and practices are greatly influenced by race and in turn affect health beliefs and actions (Bates, Rankil-Hill, & Sanchez-Ayendez, 1997; Cooper & Roter, 2003). In this respect, many studies have established that similarities between the patient and care providers tend to improve the quality of care and facilitate good relations between the patient and the carer (Bourgeault et al., 2010).

Central to the management and delivery of quality aged care is the manner in which the service encounter is managed within the intercultural context. This line of argument treats managers as, a, if not the, most critical moderating variable in processes that are designed to deliver quality care especially in an environment in which diverse cultural beliefs and attitudes might impact on the quality of interactions that take place between patients and carers. This suggests a need to briefly explore the concept of service encounters. A service encounter can be defined as a “dyadic interaction between a customer and a service provider” (Surprenant & Solomon, 1987, 87). In the same vein Czepiel(1990) view it as a form of human interaction. A more comprehensive definition of service encounters conceive it a “period of time during which a consumer directly interacts with a service” (Shostack, 1985, 243). The strength of this definition is that it captures the totality of all aspects of the service which the customer may come in contact with during service delivery such as the staff, the physical facilities (building, equipment), service systems and other customers which are all part and parcel of the service encounter and goes a long way in determining customer satisfaction (Bitner, Booms, & Mohr, 1994; Bitner, Booms, & Tetreault, 1990).

The interactions that take place between the provider and receiver of the care services play an important part in affecting the customer’s assessment of service quality. In service management literature, the term ‘service encounter’ or ‘moment of truth’ (Albrecht, 1988; Bernd & Mang, 1999;) is widely used to indicate the contact situation between service customer and service provider. It is therefore argued that, “Because a service encounter is an interpersonal relationship, we would expect that duration, affective contact, and spatial proximity play basic roles in how the service relationship develops and the outcomes of the encounter” (Price, Arnould & Tierney, 1995, 83).

Gutek (1995) however argues that encounters typically consist of a single interaction between a particular customer and provider. The parties involved do not expect to interact with the other in the future. However, the customer expects that the different providers will be
functionally equivalent (Gutek, 1995; Gutek, Bhappu, Liao-Troth, & Cherry, 1999). Gutek, et al., (1999) argue that service relationships can be divided into three categories: relationships; pseudo-relationships; and encounters. They argue that a pseudo-relationship involves repeated contact between a customer and a provider organization. In this case, the customer does not get to know any individual service provider but becomes acquainted with the service, products, and procedures of the organization. Customers do not anticipate any future interaction with a particular provider but expect to interact with the firm in the future. This situation seems applicable to eldercare facilities that have a high staff turnover rates because there is no opportunity to create long term relationships between the provider and the receiver of care.

When the customer expects to continue interacting with the same provider of the service, the two become interdependent and ultimately create a service relationship (Gutek, 1995; Gutek et al., 1999). The provision of high quality care seems to fit well into this category. The receiver of the service develops an intimacy that manifests itself in the use of possessive descriptive terms such as ‘my carer’ with reference to the care provider for example (Gutek et al., 1999; Bendapudi & Berry, 1997). If relationship is central to the quality of care the patients wish to receive, it can be argued that the management of service encounters must focus on identifying strategies of enhancing the relationships between carees and carers. The increased participation of migrants as carers justify the need for managers to consider how cultural disparities might impinge on the interactions among all these players. It can be argued that the cultural beliefs of all these interacting elements are more likely than not to impact on how care is conceptualized, delivered and received.

For example it is argued that:

“Relationships matter not only in the allocation of caring; the process of caring is itself the development of a relationship. The care a carer provides is basically inseparable from the relationship that is being developed with the person she is caring for” (Himmelweit, 1999, 29).

Like all services, aged care exhibits the characteristic of simultaneous production and consumption in which those who receive the care actively participate and subsequently influence perceived service quality ( Bernd & Mang, 1999). The ‘simultaneous production and consumption’ dimension of care brings more management challenges especially because
elderly care provisions is characterized by a high degree of person-to-person interaction. As Surprenant & Solomon (1987, 87) succinctly put it, “... in person-to-person delivery situations the service provider often is the service to the customer”. This means that it is difficult for the aged caree to separate the quality of food for example from the carer who happens to look unprofessional and unkempt, or who speaks unintelligibly that brings it to him/her.

In the context of this study, Figure 2.3 illustrates the broad context within which ‘caring of the elderly’ is located as well as the variables that interact in shaping perceived service quality. This explains why this study sees the ‘intercultural perspective discussion’ on service relationships in elderly care facilities as integral to an understanding of dynamics of quality care delivery in aged care homes. The presence of migrants does not seem to simplify the quality care delivery equation. If anything, the migrant aspect seems to complicate an already challenging relationship between the carer and the caree.
Figure 2.3 Extended, Affective, Intimate (EAI) Service Encounters

Source Price, Arnould and Tierney, (1995, 84)

The above Figure 2.3 is an illustration of the concept of service encounters. It captures the three service encounter dimensions: duration, affective content, and proxemics and shows how specific contextual organisational or environmental variables may result in service quality produced being negatively or positively received. Proxemics refers to the nature of relationships that are created, whilst affective refers to the degree of customer contact throughout the service encounter (Lovelock, 1996). It is argued that when the affect content of
the service encounter is high, customers have higher expectations of the quality of interpersonal aspects of the service encounter and feel strongly alienated when these expectations are not met. In light of how aged patients define care, affective content in care delivery can be described as high. Duration refers to the time taken in providing a service or interacting with patients.

An emerging significant question from this taxonomy of service relationships is the perceptions of managers of aged care facilities about the impacts of the migrants in aged care delivery and the role of elder care facility managers in managing the service encounters to avoid compromising elder care quality. Pursuant to this discussion therefore is the question of how elder care facility managers approach the management of the service relationships at their facilities?

2.3.3 Quality care level expectations: Hofstede’s cultural dimensions perspective

In light of the preceding view to the effect that the elderly satisfaction levels are determined by the nature of encounters they have with carers, it seems prudent to explore the complications that may emerge in the delivery of perceived quality care as migrant carers, whose cultures are different from other migrants’ and the carees’ interact. Parasuraman, Zeithaml, and Berry (1990) define perceived quality as the gap between a customer’s service expectations and his/her perceptions. In a research conducted in Canada by Bourgeault et al., (2010) they discovered that “many older adults felt that a characteristic of a good carer unique to immigrant care workers was having competency in Canadian culture. Several older adults mentioned that immigrant care workers need to understand Canadian culture before they should care for older adult Canadians” (2010). The study also noted that the aged patients viewed immigrant care workers as being “unable to relate to the Canadian way of caring because of a cultural difference” (2010, 112).

The above views should not be seen as racist or antiquated. Research has shown that care work, particularly with older people, “is by nature culturally sensitive, requiring a good understanding of appropriate eye contact or forms of address, for example…” (Hussein Manthorpe and Stevens, 2011c, 267). Cultural values and assumptions about life, modes of social interactions, behavioural norms and practices are shaped by race and in turn affect health beliefs and actions (Bates et al, 1997; Bourgeault et al, 2010; Cooper & Roter, 2003; Shaw, 2005). Bourgeault et al, (2010, 112) argue that “similarities in different cultural
characteristics between the patient and care providers improve the quality of care and facilitate good relations. Resemblances in ethnic origin, religion, and language imply that the patient and the carer are more likely to hold similar beliefs, values, speak the same language and understand each other better”. In the same vein, it is argued that “Having a shared cultural outlook and a similar set of historical references fosters a stronger relationship with a care recipient” (Walsh and O’Shea, 2009, 131). These views support the conclusion that cultural similarities aid or enhance quality care delivery.

From the viewpoint of this study, this raises fundamental question about the cultural competency of managers. As was amply established in Chapter 1, (See also Chapter 3 on this subject of the increased participation of migrants as carers), there is evidence that the aged care sector is increasingly being manned by migrants. These migrants have to adjust to fit into the new culture. This therefore prompts questions about the role of managers in developing the new sets of skills necessary to provide care that is in line with the elderly patients’ cultural definition of quality care. It is argued, for example that “Care workers are expected to be able to have a range of complex communication skills, use and interpret body language, master technical and academic discourse, and possess colloquial interpersonal skills” (Bourgeault et al., 2010, 111).

The participants’ culture, in particular that of the elderly patients seems very important in determining whether the migrant carers’ role in care provision will be appreciated or not. In this regard, Bernd and Mang (1999) have observed that service encounters are called intercultural if the service provider and the receiver share different cultures. It can be argued that since different people have different behavioural norms, the greater the distance between the cultures of these interacting participants, the less likely that commonalities concerning quality care will be established. (See a detailed discussion of this subject in section 2.3.3.1 which deals with Hofstede’s, cultural dimensions theory).

In this respect the service quality literature talks about the tolerance zone that lies between the desired and adequate service (Usunier, 1996; Zeithml et al., 1990). This discussion suggests that culture is likely to determine the tolerance levels in the event that the service provided does not match the desired expectations. Bernd & Mang (1999) make a very important point to the effect that the standards that are used in an intercultural service encounter context to judge if the service is inadequate or adequate “are home-country based, which means that they are the results of customer experiences from their home countries” (1999). Further on, the two
authors argue that an inter-cultural service provider performance gap occurs when the service performed by an individual from one culture is seen as inadequate by a customer from another culture due to expectations developed by each in their respective home cultures.

It is argued that in inter-cultural encounters all the parties involved have learnt their ‘scripts’ using their own cultures. As a result, both parties’ verbal and non-verbal communication may contain specific codes that complicate the communication process or transference of meaning. This is usually referred to as a service provider-personnel gap (Parasuraman et al., 1988). In the caregiving sector, it may manifest itself in the migrant carer ‘wrongly’ addressing the elderly patient or using some form of ‘eye contact’ that might be interpreted differently by the receiver of the care (Usunier, 1993). Perhaps from a management perspective, the question could be asked about what role managers can play in creating the necessary harmony where the delivery of care is likely to be largely influenced by this ‘migrant factor’? This also underlines the significance to managers, of taking care of ‘conceptual equivalence’ (Douglas, and Craig, 1983) in the process of managing workplaces that are dominated by persons of different cultures. Conceptual equivalence refers to the “interpretations that individuals place on objects, stimuli or behaviour, and the extent to which they exist or are expressed in similar ways in different countries and cultures” (Douglas, and Craig, 1983, 138).

2.3.3.1 Cultural disparities: Hofstede’s perspective

In order to enhance the appreciation of the complicated nature of service relationships between elderly patients and the migrant cohort of careworkers at each facility, perhaps some inspiration can be drawn from the classic work by Hofstede (1980; 1994). Hofstede (1980; 1994) characterizes the culture of countries using the dimensions of power distance; individualism/collectivism; masculinity; and uncertainty avoidance. Hofstede’s study argues that some countries are defined by a large power distance. These are, among other traits, characterized by expectation of inequality and power differences, centralized authority, autocratic leadership, paternalism, and acceptance that power has its privileges (Hofstede (1980; 1994). Those countries defined by ‘Small Power Distance’ societies are, among other traits, characterized by decentralized authority and decision making responsibility, lack of acceptance and questioning of authority, rights consciousness and a tendency toward egalitarianism. Australia, for example, is a low power distance country while most Asian countries such as Hong Kong are at the high power distance side of the spectrum (Francis, 1995). It is argued that people in high distance countries consciously and unconsciously teach
their members that people are not equal in this world and that everybody has their rightful place. However in lower power distance countries there is a preference for consultation and subordinates are happy to will approach and contradict their superiors.

In the context of a migrant care working environment, Hosftede’s ideas raise questions about how for example elderly patients that may have spent their life accustomed to great power distance will relate with their carers. To fully appreciate the weight of this view, it may be necessary to revisit the definition of culture: “the collective programming of the mind which distinguishes the members of one group or category of people from those of another” (Hofstede, 1994, 4). The traits that define a peoples’ culture tend to be relatively well engrained regardless of the fact that culture is dynamic.

This therefore begs the question: How will elder patients who may have many in-built culturally shaped ideas about care and service relationships, judge a migrant carer’s service delivery, especially if they perceive an attitude of superiority from the carer? Hofstede’s work suggest that such patients will want to occupy a position of superiority in relation to the service providers, the carers, co-patients and managers of care facilities as well.

Another question to consider is how elderly patients who would have grown up in individualistic cultural environments want to be served? It may be reasonable to surmise that such patients will likely demand and value individualised service that is adapted to their elder care needs (Bernd & Mang, 1999). Individualism is found in societies where relationships between individuals are less defined and everyone is expected to look after him/herself and his/her immediate family. On the other hand, collectivist societies are those wherein people from birth onwards are integrated into strong, cohesive in-groups, which continue protecting them in exchange for unquestioning loyalty. In this respect, Furrer, Shaw-Ching Liu and Sudharshan (2002) argue that perceptions of service quality vary across cultural groups, as defined by each culture’s position on Hofstede’s dimensions.

Another more relevant dimension of Hofstede’s work relates to his views on masculine and feminine societies. Masculinity refers to societies in which social gender roles are clearly distinct. For example men in such societies are expected to be assertive, tough, and focused on material success, whereas women are supposed to be more modest, tender, and concerned with the quality of life (Hofstede, 1991). In this respect, Furrer et al., (2002) noted that cultures will judge service quality differently depending on whether the service is provided by
a male or female service employee. Furrer et al., (2002) observed that in such a culture, customers expect a male service employee to be professional, more reliable, and more responsive than a female one, whilst on the other hand; a female service employee would be expected to be more empathic than a male one. These are all very pertinent issues in the delivery of aged care. The residents who share distinct cultural backgrounds from their migrant cares have certain expectations of service level delivery which may not be met by the migrants, especially if no visible effort is put into rigorously training them to be versatile in their approach to dealing with elderly patients in their care. Again, this suggest that the manager has an important role in determining the nature of relationships that ensue, bearing in mind that the manager has their own culture which will also influence whether they consider certain issues important or not in the actions they take to ensure quality care delivery.

In the same context, Hall (1976) distinguishes between ‘high context’ and ‘low context’ cultures. Hall argues that low context cultures are defined by explicit and specified messages. On the other hand, high context cultures use more implicit messages which are contained in the physical environment and in non-verbal communication (Bernd & Mang, 1999). High-context cultures such as those found in much of the Middle East, Asia, Africa, and South America are relational, collectivist, intuitive, and contemplative (Hall, 1976). People in these cultures value interpersonal relationships and prefer group harmony and consensus to individual achievement (Hall, 1976, Okabe, 1983). On the other hand, low-context cultures such as those found in North America and much of Western Europe) are logical, linear, individualistic, and action-oriented. People from low-context cultures value logic, facts, and directness (Hall, 1976; Okabe, 1983). For example, research shows that low context (LC) cultures, are less tolerant or do not understand diversity, and tend to be more insular (Okabe, 1983). From a communication perspective, it is argued that in an LC culture, “very little is taken for granted, greater cultural diversity and heterogeneity are likely to make verbal skills more necessary and, therefore, more highly prized” (Okabe, 1983, 38). This is an especially significant point when considered from the viewpoint of migrants who may not share an English language background and they are expected in most cases to converse with their patients in that language.

In the same context, Bernd & Mang (1999) observe that contacts between customers from high context countries on the one hand and employees from low-context cultures on the other hand, can cause considerable service gaps if habits of nonverbal communications are unknown or misinterpreted. An interesting point here is that in light of the earlier discussion
that identified that most migrant carers emerge from the developing economies, there is already an inherent conflict between them and their aged clients that in most cases come from the Western industrialised countries characterized by ‘low context cultures’. Interactions between high and low context peoples can be problematic which may require managers of aged care institutions to monitor closely the manner in which migrants, patients, co-carers and family relations of patients interact. From the perspective of this study, various questions needing inquiry emerge. For example: What role can the managers of aged care institutions play to bridge this apparent gap emanating from the disparate cultures between patients and the migrant careworkers? To what extent should the culture of the service provider be considered in the designing of service systems?

2.4 Conclusion

This chapter has reviewed literature which supports the idea of treating ‘care’ as integral to the understanding of relationships between the service providers and those who receive care. The chapter has emphasised that care, like all other services, is largely a fragile intangible concept whose quality depends largely on the relationships that are created within the whole environment. The delivery of care can therefore be easily compromised if the providers and the receivers of care do not share similar conceptualisations of care. The literature therefore highlights the importance of examining care delivery in an intercultural service encounter as well as service relationships contexts. The literature reviewed in this chapter prompts questions about the role of managers in managing intercultural care service relationships.
Chapter 3: Migrant Careworkers and Challenges in the Work Environment

3.1 Introduction

The previous Chapter explored the concept of care and how its delivery can be complicated by the participation of migrants who bring their own multicultural perspectives of quality care. This chapter builds up from the previous discussion by providing a detailed overview of migrant workers and their experiences at the work place. The chapter starts off by exploring the reasons why most aged care institutions employ migrant careworkers. The chapter then discusses the challenges migrants face in the work place. This exploration helps to contextualise the management perceptions and level of awareness regarding the challenges migrant careworkers face and their impact on quality of care delivered to the aged care patients. The literature reviewed in this chapter reflects that migrant careworkers operate in stressful environments, do stressful tasks and sometimes face racist attacks from fellow co-workers and the clients in their care. Migrants also have communication problems and tend to be overqualified for the care jobs they do. The literature brings out important question that need further attention. For example, does the employment of migrant careworkers impact positively or negatively on the quality of care? If the impact is negative, what role can managers and other stakeholders play to correct the situation? If the impact is positive, what role can managers for example, play to further support the migrants in order to enhance their delivery of quality care, especially given the unique nature of migrants’ experiences and the unique nature of care as an intangible service?

3.2 Reasons some employers prefer migrant employees to native workers.

Various studies have documented the reasons why employers across all economic sectors seem to prefer migrant workers to native local workers because the former are more hardworking and willing to take up even the most difficult of shifts (Baum, 2012; Spencer, Martin, Bourgeault, and O’Shea, 2010). Inspired by the dual or segmented labour market theory (Berger and Piore, 1980), it is argued that “the social care workforce sector as a secondary or undesired segment of the labour force, with low wages and poor working conditions, despite its importance to society, … finds it difficult to recruit from the indigenous population in many areas; particularly when the demand for workers in the sector is increasing and alternatives are available” (Hussein et al, 2011c, 288).
In the same vein, the Chartered Institute of Personnel and Development (CIPD) (2013), the professional body for UK human resource practitioners, published a report in March 2013 exploring the factors affecting the growth in employment of migrant workers from both within and outside the EU. The report explores the issues that influence employers’ decisions to recruit both EU and non-EU migrants. The most commonly cited reasons by employers for hiring migrant workers, as the Canadian research by Bourgeault et al., (2010) states

- better job-specific or practical skill (56%);
- work ethic (34%);
- better prepared for work (26%);
- more work experience (25%);
- better qualifications (23%) (CIPD, 2013, 1)

The CIPD (2013) report that one of the key reasons for hiring migrant workers from EU countries (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovak Republic, Slovenia) is that some employers perceived that migrant workers have a stronger work ethic than UK-born workers. This translates into a perception that EU workers are willing to work anti-social hours.

With reference to the aged care sector, Bourgeault et al., (2010) discovered, in their Canadian research, that employers hired immigrant care workers because they perceived them as being committed to caring for older people and being respectful towards older clients. Bourgeault et al., (2010) also found that some employers were impressed by the work ethic of different immigrant care workers such as that of Filipino workers.

In this respect, Figure 3.1 captures the reasons why employers prefer immigrants to natives, suffice to say that these reasons run across diverse studies done in the UK (Cangiano et al., 2009; McGregor, 2007; Spencer et al., 2010); Ireland (Walsh and O’Shea, 2009); New Zealand (Badkar, 2009; McGregor, 2012; Poot, 1993), and Australia Howe (2009) and Canada (Bourgeault et al, 2010).
Figure 3.1: Reasons why employers find employment of immigrant workers advantageous

Source: Bourgeault, et al., 2010, 74

The diagram reflects migrants as largely more positive in their approach to carework compared to their indigenous counterparts in three different contexts: urban; suburban; and rural. The positive dimensions of migrants indicated in the diagram make them more attractive to the care industry employers.
3.3 Migrant workers’ employment: insights into some challenges

Notwithstanding these advantages, research on the employment of migrants suggests that at this whole process is replete with diverse challenges (Bourgeault, et al., 2010, Walsh and O’Shea, 2009; Spencer et al, 2010). It is however important to note that in light of the diversity that characterises migrant workers, circumstances and motivations, “it is impossible to generalize the experiences of migrant workers, which may vary from working illegally under exploitative terms and conditions, to working in highly paid, rewarding and skilled jobs” (Lucas & Mansfield, 2008, 7). From the perspective of the employer, some of the challenges include the added costs of training, communication difficulties and cultural disparities between the culture of the cared-for-person and the migrants’ (Walsh & O’Shea, 2009).

Figure 3.2 sums up the challenges associated with the employment of migrant care workers from the perspective of Irish managers (Walsh and O’Shea, 2009). The employment of migrants comes with some administrative, training and performance costs emanating from their poor knowledge of Irish culture, and poor English proficiency.

![Figure 3.2: Challenges associated with the employment of the migrant care workers in Ireland](image)

These various challenges captured in Figure 3.2, with reference to Ireland, are also common to many other Western industrialised countries. For example, Cangiano et al., (2009, 86) found that migrants generally tend to have poor English language proficiency skills, require extra job training, are not easily accepted by clients; lack decision making skills; lack assertiveness; and often leave the job poorly educated. (Bourgeault et al., 2010; Spencer et al., 2010)

Many of the studies record that most employees perceive the English language proficiency of immigrants as interfering with their ability to provide quality care to the elderly (Walsh and O’Shea, 2009; Cangiano et al., 2009). In this respect, it has been argued with reference to the UK and Norway that:

“Unlike the (natural) experience of language for native or first language speakers in a country, language has a rather, what we want to call ‘troublesome’ character for migrants. Their experiences with language mirror the comprehensive functions of language, ranging from being a tool for communication to being part of an identity and shaping the experiences of social inclusion. In both countries we find language representing a key issue within the filter of social inclusion” (Christensen and Guldvik, 2013, 16).

These few preceding paragraphs have focussed on the benefits and challenges that emanate from the employment of migrants. However, in order to contextualise further the managers’ perceptions regarding the employment of migrants as careworkers in the context of quality care delivery, the following sections explores the work place experiences of migrants. This is important in this study because it reveals some common generic challenges that migrants elsewhere face, which may require or call on managers of aged care institutions to devise some innovative strategies to ensure that the challenges that the migrants face do not impair their ability to deliver quality care to the elderly patients.

3.4 The experiences of migrant workers across all economic sectors

Migrant workers are found in almost all the sectors of the economy. They are mostly defined by vulnerability emanating from their low incomes, poor benefits, unstable employment, and the realities of operating in a new environment without traditional family support systems (Stevens, Hussein, & Manthorpe, 2012). As marginal workers they are often willing to work for rates of pay and under conditions of employment, that would not be acceptable to native-
born workers (Lucas & Mansfield, 2008). In this respect, a number of studies across sectors have documented various challenges faced by migrants. Most studies agree that migrant workers often have qualifications and skills beyond those needed for the jobs they are doing (Spencer, Ruhs, Anderson & Rogaly, 2007; Spencer et al., 2010; Stone, Dawson & Haraham 2004). The International Labour Organisation’s (ILO) statement below aptly captured the challenges that are faced by migrant workers:

“Many migrant workers … suffer from poor working and living conditions. They are paid lower wages and endure informal or casual employment services in a less safe and favourable working environment than native workers. Women in irregular status are particularly vulnerable as they are also in danger of sexual exploitation” (ILO, 2010, 37).

In this respect, Wright and Pollert (2006) documented in great detail the experience of ethnic minority and migrant workers in the Hotel/Restaurant/Catering (HoReCa) sector, highlighting the vulnerability of this marginal workforce. In Japan, for example random audits and interviews conducted during 2010 confirmed a range of non-compliance with respect to migrant workers. These include forced labour, withholding passports, not paying the legal minimum wage and lack of access to grievance channels (Adidas Group Survey, 2010).

### 3.5 Experiences of migrant workers in the elder care industry

The challenges faced by migrant workers in the care sector are generally similar to those experienced by workers in other sectors of the economy. Once at the work setting, migrant carers experience some challenges that may easily impact on how they work towards the achievement of organisational goals. The challenges discussed here do not in any way diminish the fact that immigration can also be empowering, especially for women migrants that gain additional skills, higher self-esteem and increased economic independence which should be understood (Baum, 2012). In this respect, it is argued that although migrants would like to find jobs where they could use their skills more fully, in some cases they take up jobs below their skillset and qualifications because employers do not recognise foreign qualifications (Spencer, 2010; Walsh and O’Shea, 2009). In other cases, this skill mismatch can be due to language barriers and to workers’ willingness to take any available jobs.
To this end, diverse literature has documented the challenges that migrant workers face in the care sector (Cangiano et al., 2009, Spencer et al., 2010; Walsh and O'Shea, 2009). Most of these challenges have been shown to have severe implications on the integrity and image of the aged care sector and the quality of care the elderly receive (Bourgeault et al., 2010). The experiences of migrant careworkers can be put under the following categories: underemployment, remuneration challenges, discrimination and access to employment rights, scarce training and professional development opportunities, need for recognition, poor conditions of service and perceived lack of management support.

Figure 3.3: Migrant carer challenges

Source: Lamura, (2010, no page)

The circled or highlighted aspect in figure 3.3, ‘cannot get out of home’, is as it is in the original document. This study is not interested in ranking the dimensions or placing value on the different dimensions. The diagram above is only provided because it depicts Lamura’s (2010) summary of findings related to the difficulties that migrant carers face, suffice however to say that native workers experience some of these challenges, although the severity may differ. This is, by no means, a comprehensive list of the grievances migrant workers in
general have raised, but the few listed here will serve the purpose of this study. The following sections will explore a few of these challenges as an indicator of the areas that management of aged care institutions may occupy themselves with in the desire to improve the performance of the workers for quality care delivery.

3.5.1 Underemployment

Migratory status and labour market dynamics can combine to restrict skilled and highly skilled migrants to low-skilled occupations regardless of their often high human capital. Research conducted in the UK for example discovered that many migrants with a variety of prior skills and occupations fail to work at their desired level or in the sector they trained for (Burd, 2013). Burd (2013) also noted that care jobs sustain high demand but are frowned on by the local population. As a result “they are increasingly becoming a repository for migrants who cannot find work elsewhere or are making their first steps in the UK” (Burd 2013, 1). This phenomenon is described as ‘underemployment’. Maynard and Feldman define underemployment as “when workers are employed in jobs which are substandard relative to their goals or expectations” (2011, 1). Underemployment generally denotes an “inferior, lesser, or lower quality type of employment” (Feldman, 1996, 387). In this regard it has been observed that,

This phenomenon of highly qualified migrants being pushed into underemployment or lower-skilled occupations, with the risk of losing their skills, is a reality with strong negative economic and social implications for migrants themselves and also for host and home countries. This deskilling is also a manifestation of the stiff barriers that remain to the mobility of people and talents (Mollard and Umar, 2012, 5).

Mollard and Umar’s (2012) study is however more focussed on the female category of migrant carers. They observed that the existence of an unmet demand for low-skilled care services in the host country has tended to worsen the risk of deskilling of especially migrant women. Their study shares the view of many other studies that have argued that, for most migrants, carework may be a necessary devil.

McKee-Ryan and Harvey (2011) observe that underemployment is a multi-dimensional concept and define the ‘underemployed’ as “inadequately employed, underutilized, underpaid, overeducated, overkilled, and overqualified or as having low skill utilization or reemployment quality”. Feldman (1996) argues that underemployment can be expressed in many different
ways. For example, there is ‘pay/hierarchical underemployment’. This refers to workers who are underpaid or at a lower hierarchical status compared with their former job status (Feldman, 1996). Such employees feel that they are not being compensated adequately for the job they do. Another form of underemployment is ‘hours underemployment’. This represents workers who are currently working less than full-time but who have a desire to work more hours (Creed & Moore, 2006). In this respect the desire to work more hours is what distinguishes this type of underemployment. Another form of underemployment is ‘Work–status congruence’. This represents a mismatch between employees’ preferences for and actual full-time or part-time status, schedule, shift, and number of hours (Holton, Lee & Tidd, 2002).

Yet another form of underemployment is ‘over-education, or underutilization of education’. This refers to the degree to which a worker is required to have his or her educational level in his or her job (Maynard & Joseph 2006). Another form of underemployment is ‘job field underemployment’. This is reflected by a person working outside his or her field of formal education or training (Burke, 1997). This can be contrasted with ‘skill/experience underutilization’ which occurs when an individual possesses greater skills and/or work experience than required; employees are asked the extent to which they are able to utilize their broad repertoire of skills within their current jobs (Feldman et al., 2002). Perceived over qualification, occurs when workers identify themselves as overqualified for their jobs: these workers perceive that they are overqualified and have more education or skills than their jobs require (Erdogan & Bauer, 2009; Maynard & Joseph, 2006). Finally, ‘relative deprivation’ underemployment encompasses both the perception that a job is lacking in some way and the belief that the job should be better than it is. As such, it includes individuals wanting more or feeling entitled to more from their jobs, or employment mismatched with education and training (Feldman et al., 2002; Feldman & Turnley, 2004).

Feldman (1996, 390) argues that there are several aspects of this conceptualization of underemployment. He argues that in each dimension, underemployment is a type of discrepancy or deviation. In some dimensions, the standard of comparison could be the person’s past achievements. In other dimensions, the standard of comparison is the work and educational histories of co-workers, whilst another standard of comparison is the person’s own expectations and desires. In all these cases, underemployment is defined by a discrepancy between “satisfactory employment” (Kaufman, 1982) and current employment.
An important point to consider especially with regard to the possible impacts of underemployment on the achievement of organisational goals is hinted at by Maynard and Feldman (2011) who argue that ‘underemployment hurts’ and can have serious negative consequences both in the short- and long-term on job satisfaction, career success and personal wellbeing. Feldman (1996) also concurs with this view of the indicators of underemployment. These are, in his view, depressed career trajectories, lower job-satisfaction and increased intention to quit. In this study, this is of great significance especially when considered from the view that quality care as intangible and largely dependent on the nature of encounters that take place between the aged care patients and their migrant carers.

In light of this general literature on underemployment, most migrant careworkers can in fact, safely be described as ‘underemployed’. A study conducted in the UK by Cuban (2012) records that carers, many of whom were former health-care professionals (nurses, midwives, and physical and occupational therapists) in their countries of origin, described their care work duty of helping clients and the vocational types of skill-sets that came with the job, such as complying with task-based basic activities and procedures, problematic. This was because they were not using their former professional skills or university-based expertise; hence, they felt “deskilled”. The migrant workers’ challenge of ‘underemployment’ is significant because it is also connected to other challenges such as the lack of opportunity for training and personal development that migrants deal with once employed.

Another important point to consider is that underemployment is generally seen as having an inverse relationship with quality care. For example a study on the underemployment of physicians concluded that “the quality of the care provided by these physicians is inadequate” (Frenk, Javier, Nigenda, Munoz-delRio, Robledo, Vaquez-Segovia, and Ranurez-Cuadra (1991, 26).

The concept of underemployment therefore raises a lot of questions. In light of the fact that most migrants doing carework experience some form of underemployment, it may be necessary to investigate the managers’ understanding of the possible impacts of underemployment on the commitment levels of the migrants to quality care delivery. Another important question relates to the management’s perceptions of the strategies that have to be adopted by management to ensure that underemployed migrant careworkers behave in a manner that is consistent with the values of the organisation in the context of high quality care delivery.
3.5.2 Remuneration challenges

Another significant challenge that migrant carers face relates to pay rates. Walsh and O’Shea (2009) and Spencer et al., (2010) recorded complaints from many carers in Ireland and the UK about the generally poor rate of pay for older adult carers. The interviewed carers felt that the low salary rates reflected that the authorities did not prioritise carework in comparison to other jobs. It is however important to note that this issue is a sectorial concern as well. There is however research that suggests that migrants perceive that their pay rates are generally lower than those offered to their native co-workers (McGregor, 2007). From the viewpoint of performance, it is important to note that pay inequality is a main cause of job dissatisfaction and de-motivation (McLoughlin and Carr, 1997). In this respect Walsh and O’shea (2009) argue that “While the effects of insufficient remuneration are reasonably direct, the migrant care workforce are also likely to be increasingly influenced by the more subtle issues of poor career pathways, lack of prestige and the pull of other sectors”.

In the UK, an Oxfam Report, by Gentleman (2009) described widespread exploitation of migrant care workers, revealing that they are routinely forced to work excessive hours, often with no holiday or sick pay, and also being required to be on call for no extra pay. Gentleman (2009, 1) also suggests that the exploitation within the carework sector was characterised by “underpayment of wages, debt bondage, excessive hours, spurious deductions, dangerous and unsafe working conditions”. Other studies conducted across Europe, the USA and Canada report that migrant careworkers view their remuneration as largely inadequate in comparison to the tasks they perform (Eaton, 2000; Stone et al., 2004).

Research in the UK, Ireland, and the USA (Spencer et al., 2010) also recorded complaints from migrant workers about being allocated fewer shifts which necessitated that they look for other jobs to augment their meagre earnings. Maintaining two or more jobs created a lot of pressure for them, yet this was a necessary move to make a living. Research done in the UK corroborates this line of argument by observing that “Rushing from one job to the next meant that care workers could not see to all of the needs of one care recipient before having to move on to their next client” (Datta, McJlwaine, Evans, Herbert, May & Wills, 2006, 16).

In this regard, a study conducted in New Zealand made some very interesting observations which imply that the aged patients’ welfare is at high risk from the participation of migrants as carers, especially if nothing is done to ameliorate the migrant carers’ suffering:
“Tiredness from working double shifts to pay onerous bonds, little knowledge about possible support systems lack of money, a feeling of hopelessness when they were hoping for a new start, all compound into a quiet human tragedy happening right in our neighbourhoods” (Labour and Green Parties & Grey Power, 2010, 37).

This description of the position of migrant carers raises questions about the ability of workers who encounter such problems to adequately deliver care to the satisfaction of aged patients, especially in light of how the aged patients, as was discussed in Chapter 2, Section 2.2.1, conceptualise quality care.

Closely connected to the challenge of underemployment and poor pay rates is the lack of training and personal development opportunities for most migrants. This is despite the Institute of Medicine’s (1986) report that states “improvements in aide training and job responsibility will help to improve nursing aide skills, elevate their self-esteem, improve resident care, and, perhaps, decrease nurse’s aide attrition rates as well” (p. 91). Increasing standards for direct care workers training is one of five major requirements, along with improved recruitment, retention, wages, and benefits, in ensuring a quality elder care work force.

From a research perspective, it is however important to question the extent to which a manager of a facility can influence salary and conditions of service? How can managers of aged care institutions deal with the tension between shifts and income for migrant workers in particular?

3.5.3 Discrimination, racism and access to employment rights

Another important area of concern that has defined migrant carers’ experiences has to do with discrimination and access to employment rights. This issue is not particular to the aged care sector but pervades many industry work relationships. Some studies have even looked at discrimination using gender lenses. For example, the ILO report highlights the following forms of discrimination that are faced by women migrants in general raising questions about whether gender should be considered an important variant by managers in the manner in which they manage the diverse groups under their supervision.
Figure 3.4 Women migrant workers challenges

Source: International Labour Organisation (Undated, 3)

In this respect, a study in Australia by Barrett, Sonderegger, & Xenos (2003) noted that migrants face problems such as language and cultural barriers, lack of recognition of their qualifications, concentration in unskilled jobs with no opportunity for advancement, and high rates of unemployment. A study by Kofman, Lukes, D’Angelo & Montagna, (2009) found that migrants were more likely to experience racism both in the workplace and in the community than UK nationals from Black and Minority Ethnic (BME) groups. Racism and discrimination is perpetrated in diverse forms that range from individual racist comments, or a refusal to receive services from workers of noticeably different ethnicity (Cangiano et al., 2009 & McGregor 2007,), to the under-representation of migrants in managerial and professional positions (Kofman et al., 2009). Discrimination refers to “any practice that makes distinctions between different groups based on characteristics such as sex, race, age, religion… that results in particular individuals or groups being advantaged and others disadvantaged” (Fastenau, 2008: 563). In this respect, some studies have documented that workers from black ethnic groups tend to experience the most direct racism, particularly from service users themselves (Holgate 2005).
A study on recruitment practices in Australia by McAllister & Moore (1989), for example, showed that Asians were the most disliked racial group, followed by blacks and aborigines, whilst Islam was the most hated religion. Crabtree & Wong (2012) also discovered that in Hong Kong, there exist considerable prejudices against Filipinos, Indians, Nepalis, Pakistanis and Mainland Chinese.

Another related challenge that migrants carers encounter relates to their inability to speak English fluently. Research by Bourgeault, et al., (2009) about the experiences of migrant careworkers in Canada concluded that the nature of relationships between carers and clients, and the quality of care was affected by the language barrier between the carer and the cared-for-person. Redfoot & Houser (2005) also observed that language barriers are critical cultural issues. The same views are reinforced by observations in a study by Polverini & Lamura (2004) of foreign home care workers in Italy, which found that 36 percent of family-hired personal assistants and 16 percent of agency-hired workers had no knowledge of Italian and more than half had insufficient understanding of written Italian. In the same context, Redfoot & Houser (2005) observed that in the United States, 11.8 percent of nurse aides in long-term care settings could not speak English or could not speak it well. It is important to note however that the problem of communication goes beyond understanding the host country’s language or being able to speak it. For example it is argued that even when an international worker is fluent in the language of the host country, different dialects and accents can be an obstacle to communication and can stigmatize the nurse (Allan and Aggergaard, 2003). A study conducted by Creese & Ngene Kambere (2003) for example, found that employers discriminate against language accents, rather than actual language ability, when hiring African women immigrants. In this regard, research focussed on the aged care sector found that migrant workers also perceive discrimination emanating from their abilities to proficiently speak and write English (Cangiano et al., 2009; Doyle and Timonen, 2009).

A study by the Migrant Rights Centre Ireland (MRCI)(2012) came up with some interesting findings about careworkers’ working conditions. Although some workers reported good pay and conditions, most of them complained that they did not receive their basic rights, including overtime and bank holiday pay, among other rights and entitlements. In the same vein, it has also been noted that employers also practice racism and discrimination. These practices are characteristically displayed in poor conditions of service, unfair work allocation and restricted opportunities for progression for the migrant workers (Cangiano et al., 2009; Kofman et al., 2009; McGregor 2007). Research by Doyle and Timonen (2009) found that African carers
were critical of discriminatory acts perpetrated by care recipients, work colleagues and managers.

The same study also recorded complaints from one South African carer who had experienced some form of racism or prejudice at work. This carer felt that co-careworkers and the managers practiced unfairness and discrimination and felt that they colluded in, or tacitly accepted, racial behaviour (McGregor, 2007). The worker felt that “incidents of workplace discrimination exemplified unequal work relationships between White co-workers and supervisors and Black care-assistants” (Doyle and Timonen, 2009, p.6). Doyle & Timonen’s (2009) study on the African migrant care workers’ experiences of the long-term care sector emerged with some interesting findings about workplace support to deal with incidents of racial abuse at work. The interviewed migrant careworkers said that their workplaces had no formal support mechanisms or complaint channels to assist those who experienced racial discrimination. The carers said that they were instead, encouraged to resolve the situation themselves, which tended to result in confrontations.

These findings are very interesting especially in the manner in which they resonate with Näre’s (2013) study on Finland’s migrant workers. Näre found that the employers, whilst aware of the existence of racism, they nevertheless could not do

“much to change the racist attitudes of older people. Although the employer has the goodwill that everyone should respect each other, she is reluctant to take any significant measures to help the worker who has encountered racism. It is then the employee who has to bear the responsibility and the burden of being different on his own” (2013, 77).

This attitude of managers towards the problems raised by migrants could easily be seen as complicit discriminatory and racist behaviour.

Research is consistent in its view that workplace discrimination operates in different forms. For example, most migrants interviewed in the UK (Cangiano et al., 2009; Spencer et al., 2010; Ireland (Walsh and O’Shea, 2009), and Canada (Bourgeault, et al., 2009) perceived inequalities and discrimination in employment relations on grounds of race and of nationality (Spencer et al., 2010; Walsh and O’Shea, 2009). These perceptions developed on the bases of what migrants considered unfair and unethical management practices in the allocation of hours of work and the tasks involved; the wages and social protection of workers; access to
training opportunities and promotions; and complaints, disciplinary and dismissal procedures (Spencer et al., 2010; Walsh & O’Shea, 2009).

Cangiano et al., (2009) and Spencer et al., (2010) report that in addition to divisions in the allocation of hours of work, some Zimbabwean migrant workers in the UK complained about inequalities in the division of tasks between care workers, based on race or immigration status. Some of these Zimbabwean migrant respondents complained about being allocated the ‘harder tasks’ or the more ‘difficult residents’ as compared to their White care workers counterparts, the latter invariably described as ‘friends of the management’ (Spencer et al., 2010). In Cangiano et al.,’s (2009) study, a Chinese careworker also complained about being allocated hard tasks and being subjected by the White British and East European managers and nurses, to long hours of work without breaks. Additional studies of migrant workers from Poland and the Philippines reported similar perceptions of inequality in shift allocations. A Polish worker for example complained about unfair division of weekend shifts between migrant workers from Poland and the Philippines and English care workers (Spencer et al., 2010; Walsh & O’Shea, 2009). These views prompt many questions from the viewpoint of what managers in the care sector in New Zealand are doing to promote equality at work. This preceding discussion also brings up questions about the need to investigate the different kinds of racism experienced by migrant care workers, and as put across by Stevens, & Manthorpe “the support they receive in terms of balancing their right to protection, managing the workforce, and respecting the choice of people using social care services” (2012. 1).

Research conducted in New Zealand about migrant work experience showed that many immigrants face huge difficulties in transitioning into the New Zealand labour market and that they experience discrimination (Basnayake, 1999; Sayers, 2008). Spoonely (2007) argues that migrants are discriminated in many ways such as having their other work and qualification credentials being questioned as well as their language skills and religious beliefs.

In the case of New Zealand, the Human Rights Commission (HRC) Report by McGregor (2007) also shows a high prevalence of complaints from migrants about their exposure to racial harassment. The HRC report however does not go near to capturing the full extent of this racial harassment since “new immigrants do not want to ‘make waves’, and they (also) do not know about the complaints system in New Zealand, nor how to access it” (Sayers, 2008, 94).
The literature supports the view that many employers and care recipients construct racial stereotypes and tend to have a preference for certain nationalities that they consider as having a close affinity to positive aspects such as being nurturing, docile, warm and caring (Anderson & Rogaly, 2005; Yeates, 2005). In this respect, Gawronski, Peters, Brochvant & Strack, (2008) make a distinction between ‘old fashioned’, ‘modern’ and ‘aversive’ racism. They define ‘old fashioned’ racism as open and direct and closely associated with non-egalitarian beliefs, particularly in the superiority of white people. They also define ‘modern’ racism as involving undesirable feelings towards people from dissimilar ethnic groups, which persevere notwithstanding confirmed beliefs in equality. It is also important to note that racism and experiences of racism can be elusive (Hancock, 2007). It is however generally agreed that racism involves an “attempt to fix human social groups in terms of natural properties of belonging within particular political and geographical contexts” (Solomos and Back, 1996, 27, original emphasis).

This preceding discussion raises a number of questions about management interventions to mitigate the suffering of migrant workers. These experiences migrant workers raised in the literature raise a very important question for this study: In the context of New Zealand’s aged care sector, what do these experiences of perceived discrimination and racism elsewhere communicate about managing migrant workers in elder care facilities? Another question raised relates to the nature of competences that are needed by managers in the current globalised environment in which workplaces are defined more by diversity than uniformity of cultures. Indeed due to the increased participation of migrants as carers, it can be argued that the opportunity for cross-cultural interactions is greater than ever and will only increase in the future. In a world where crossing boundaries is routine, cultural intelligence has become a vitally important aptitude and skill for all managers (Earley and Mosakowski, 2004). Questions about the cultural intelligence levels of the aged care facilities managers therefore emerge here. Cultural intelligence refers to the ability of people to deal effectively with the cultural aspects of their work environment (Earley and Mosakowski, 2004). In the context of this research, it can be assumed that a manager who is not culturally competent may face difficulties in motivating diverse workforce as well as understanding and dealing effectively with issues that are of concern to them.
3.5.5 Careworkers’ need for recognition

Many studies have documented the low regard with which nurse aids and carers, migrant or native, are held. Eaton’s (2000) research, for example, found that direct care workers felt unrecognised and disrespected by their managers as well.

As evidence, one manager is quoted saying that:

We can’t involve employees in developing systems with a customer focus... The great majority of people who do nursing aide, housekeeping, laundry, and food service work are there because it is the best job they can get currently... they have a low sense of self-esteem... These people are not like you and me, [they] do not see life as something to take charge of. They see life as one uncontrollable event, something that happens to them.... You cannot walk in the door with a typical TQM project, you can’t tell them to accept responsibility for the care giving system, you can’t tell them to work in a quality team environment, because to do any of that requires them to take charge of their jobs. And they can’t do that (Eaton, 2000, 597).

This attitude perhaps explains partly explains why health care workers feel unvalued and ultimately lose a sense of ownership in the tasks they do. Such recalcitrant attitudes also show a clear denial of the irrefutable fact that nursing assistants have the primary contact with older nursing home residents and provide an estimated 80% to 90% of their care (Hall, 1983). Their performance is, therefore, crucial in determining the quality of residents’ mental and physical health care (Smyer, Brannon & Cohn, 1992). To this end, some studies have therefore underscored the importance of including nursing assistants in care planning and providing feedback to help assistants understand the connection between interventions and resident outcomes.

Some studies have attributed blame to managers for the high turnover of direct care workers. Management was accused of being “uncaring, uninvolved, and out of touch with the workforce and the workplace” (Mittal, Rosen, & Leana, 2009, 628). Many direct careworkers left their jobs because they “perceived lack of respect for the work, primarily from management, and to some degree from the larger society as well” (Mittal et al., 2009: 627).

In the same context, research by McGilton, Hall, Pringle, O’Brien-Pallas, & Krejci (2004) on supervisor relationships in nursing facilities found that direct care workers looked at various personal and professional factors to determine whether or not their supervisors displayed
supportive behaviours. Most carers interviewed said that they considered the supervisor’s attitude and personality, teamwork, mutual support, breadth of knowledge, ability to delegate, and willingness to share information. Research by Bowers, Esmond, & Jacobson (2003) discovered that direct care workers in nursing facilities felt unappreciated and that they had poor relationships with supervisors (Kemper et al., 2008).

**3.5.6 Poor conditions of service: Job design challenges**

Most studies agree that whilst direct care workers provide the bulk of long-term care, they nevertheless provide care under stressful working conditions, and often do not have opportunities for career advancement, and are among the lowest paid workers (IOM, 2010; Martin, Bourgeault, and O’Shea, 2010; Spencer, Stone, 2004; Stone & Weiner, 2000). It is argued for instance that

“The lack of formal qualifications is one of the main reasons why aged care work is of low status and is low paid. The conundrum is that low pay does not encourage taking up training opportunities, but low qualifications lead to low pay” (NZ Human Rights Report, 2009).

In the same vein Stone (2000) argues that the adequacy and availability of a trained workforce is the most ignored dimension of long-term care policy. This is despite observations to the effect that the development of appropriate training programmes can play a significant role in changing the poor image of many long-term care jobs, thereby attracting more people to the sector and, in addition, helping to guarantee quality standards (Fujisawa & Colombo, 2009).

Conflict among varied roles and ambiguity over the content and responsibilities of these roles may lead to increased job stress and decreased job satisfaction (Fisher and Gitelson, 1983). Eaton (2005) recorded complaints from carers to the effect that their jobs lacked opportunities for teamwork, and that they were given too much work, too many patients and a lot of paperwork and often worked with inadequate supplies. In a related context the U.S. Department of Health and Human Services argues that “Manageable caseloads and workloads can make a real difference in a worker’s ability to spend adequate time with children and families, improve staff retention, and ultimately have a positive impact on outcomes for children and families” (Child Welfare Information Gateway, 2010, 1). This is a strong argument that links working conditions staff retention and quality of outcomes.
With reference to the aged care sector and migrant carers in particular, research conducted in the UK (Cangiano et al., 2009), Ireland (Walsh and O’Shea, 2009) recorded complaints from many carers to the effect that they were allocated unsociable shifts as well as difficult clients.

3.5.7 Perceived lack of management support

Research by found out that that direct careworkers identified improved work relationships as one of the important most important things their employers could do to improve their jobs (Kemper et al., 2008). In the 1980s, research on nursing assistants identified the organization’s management style, such as supervisors with ‘good people skills’, ‘promotion of worker autonomy,’ as the most important predictor of higher job satisfaction and lower turnover rates (Kemper et al., 2008). One of the latter study’s most important findings was that homes in which nurse supervisors accepted nursing assistants’ advice or simply discussed care plans with the aides, reported turnover rates that were one-third lower than those without these practices.

A study on the factors influencing healthcare workers’ job satisfaction found that the relationships created between the care worker and their dementia patients, as well as their families was a major job satisfaction element (Ryan, Nolan, Enderby, & Reid, 2003). It is argued that Job performance is influenced by job satisfaction (Judge, Thoresen, Bono, & Patton, 2001). For example, research findings by Feldman, Leana, & Bolino (2002) indicate that workers were more satisfied with their jobs if they felt personally responsible for their work, had more discretion about how they did their work, received on-going feedback from their supervisors, and had good relationships with their clients.

This suggests that relationships between facility care workers and care recipients, as well as workplace characteristics, are key factors affecting workers’ job satisfaction. Perhaps more important is what this brief discussion on job satisfaction implies for the management of aged care facilities. Since research shows that the relationship between individual workers and their supervisors promote increased subordinate satisfaction, performance, and career outcomes as well as reducing the tendency to leave the job (Gerstner & Day, 1997), it can be concluded that the managers of aged care facilities can play a role to engender healthy workplace relationships conducive to quality care delivery. For example, research by McGregor’s (2007) in the United Kingdom recorded complaints from Zimbabwean migrant careworkers who felt
that their work was frustrating, stressful and exploitative. These workers felt that management colluded with family relations of patients as well as the native co-workers to commit discriminatory acts (Doyle and Timonen, 2009).

3.6 Carework and potentials for occupational stress

Having catalogued these various challenges migrant carers encounter at the work place, it is only fitting that the this section focuses on the challenges that emanate from the nature of the job itself or the nature of tasks that characterise the care job.

Characterisations of carework are largely dominated by many of the qualities that have been identified to cause stress (Spencer et al., 2010). For example, a study by Bourgeault et al., (2010) and Spencer et al., (2010) recorded complaints from some immigrant care workers about being allocated heavier workloads and more difficult clients due to their immigration status. Studies done across Europe and Canada (Spencer et al., 2010) also recorded complaints about the busy and hectic nature of the older adult care work setting which placed a lot of pressure on them. Studies noted that the hectic work environment was mediated by the dependency level of the older person being cared for (Bourgeault et al., 2009; Eaton, 2001; McGregor, 2007; Spencer et al., 2010; Stone, 2004; Walsh & O’Shea, 2009). In this respect, various studies (Lee & Ashforth, 1996; Boxer, Burnett & Swanson, 1995) have identified role ambiguity, role conflict, heavy work-load, pressure, and physical discomforts as common stressors. These characterisations of carework are important in light of the complaints from migrants to the effect that they perceived that they were allocated more difficult patients to provide care for, compared to those that were allocated to indigenous carers (McGregor, 2007).

Characterisations of care job tasks and the general working environment reflect the job as having a close affinity to factors that cause occupational stress. Direct care workers have regular and on-going contact with vulnerable adults, providing personal and sometimes intimate care, often without direct supervision (Applebaum & Phillips, 1990). They are relied on to notice and report changes in health, behaviour, as well as handle challenging clients and families (Harmuth, 2002). Like family caregivers, direct care workers may experience burden and burnout, with negative consequences for elders under their care (Noelker, 2001). Providing direct care to vulnerable elders is a demanding job. Although these stressors are not unique to migrant carers, it is however suggested that in light of preceding discussions
about the raft of challenges migrants encounter which appear to outmatch those generally encountered by their indigenous counterparts, the nature of tasks of carework might have more telling impacts to the migrant carer with repercussions for quality care delivery.

Given the care profession’s client-centred nature, stress is a concern among social workers particularly among those providing direct services (Pollock, 1988). These characterisations of care work and the challenges emanating from the highly interactive service relationship nature of carework, supports the view that carework has a high probability of causing occupational stress which may have subsequent negative impacts on the manner in which carers deliver their service.

Figure 3.5, although not specifically designed for the aged care sector, captures the diverse factors that may shape the manner in which, not just migrant carers, but all carers deliver care to their elderly patients. Applied to the aged care sector, the diagram supports the view that culture, demands placed on the carer, job control or lack of it - all very common occurrences in the care sector- , relationships with carees, carees’ family relations, co-carees and management can cause stress.
Figure 3.5 Model of Work Stress

Source: Palmer, Cooper & Thomas (2001)

Working conditions and work tasks therefore are important determinants of stress. Stress is caused by a poor match between the worker and the work, by conflicts between roles at work and outside it, and by not having a reasonable degree of control over work and life balance. Stress at work can be caused by a multitude of stressors. This is also relevant to care work.
which in many cases is characterised by heavy workloads, difficult patients, mismatches between the worker and the work, little support from supervisors, and poorly remunerated jobs (McGregor, 2007; Spencer, et al., 2010 & Walsh & O’Shea, 2009). In response to the stress, and in order to cope by maintaining psychological and physiological homeostasis, workers in general resort to many strategies.

In this context, a research done in the USA (Eaton, 2001) categorised nursing homes into high quality, low quality and medium quality care providers. The research noted that in low quality care giving homes, the work system was labour-intensive, and that workers received little or no supervision on how to do tasks required of them, nor did they receive feedback on effects of their work. They also receive no information about the condition of the residents to whom they were assigned. There was also no one to help them make sense of multiple simultaneous demands on their time. Training was minimal, and equipment and essential supplies such as fresh linen and clean gloves were frequently unavailable.

3.6.1 Behavioural consequences of a stressful work task: dangers to quality care delivery

In light of the discussion above about work stress, a more interesting thought worth exploring is the manner in which workers ordinarily respond to stressful working conditions and the possible impact on the quality of outputs. Aged care sector deliverables could include satisfied aged care patients, happy workers and a generally conducive working environment. The way in which the workers deal with the high pressure associated with the challenges of performing highly personal and interactive job tasks such as care giving, can disrupt the delivery of quality care to their clients. The manner in which these workers cope with their job is important, especially in the context of their ability to deliver consistent high quality levels of care to their clients. In the case of migrant carers, they have to deliver in the area of compassion, politeness and genuine show of concern for their carees. Such intangible dimensions of care do not seem compatible with the behaviour patterns that are normally exhibited by stressed individuals. Perhaps this also highlights the role that the managers have to play in making sure that the service encounters are not affected negatively by some of the negative coping strategies that may be adopted by a stressed worker.

Coping is a cognitive-behavioural process that takes place in the context of a situation or condition perceived as personally relevant, challenging, or that exceeds an individual’s resources to adequately deal with a problem (Lazarus & Folkman, 1984). Coping is learned
behaviours that contribute to survival in the face of life-threatening dangers (Ursin and Eriksen, 2004). Chang et al., (2006) argue that coping efforts may be directed externally, that is they may be focused on a problem, or emotion-focused, that is internally. Chang et al., (2006) also posit the view that problem-focused coping may be viewed as attempting to manage or change the problem causing the stress, whereas emotion-focused coping attempts to alleviate emotional distress.

From the viewpoint of quality service delivery, perhaps what is of fundamental importance here are the coping strategies or the strategies such stressed individuals resort to in order to master, tolerate, reduce or minimise these impacts. In the context of careworkers, perhaps one of the most damaging reaction to the quality of care provided, as a result carers attempting to cope with stressful work environment, is when a carer desensitises or emotionally distances themselves from their carees. As discussed earlier on, carees perceive quality in terms of the nature and quality interactions they have with their carers. An emotionally detached carer cannot be relied upon to provide consistent high quality care to the patients. Other reactions to stress causing situations that may also impinge on quality care delivery include confronting the perceived cause of the stress, or escaping from the stressful environment (Folkman and Lazarus, 1991; Chang et al., 2006). A carer who perceives racism from the caree might therefore confront the caree. Confrontation and conflicts are generally not consistent with high quality care delivery especially in light of the view that pleasant and positive relationships, feelings and attitudes between staff and residents are generally considered crucial to quality of life and care by elderly patients (NCCNHR 1985). Furthermore, it can be argued that once an employee responds to work pressure by adopting the avoidance strategy, they are more likely than not to cease belonging to the circle of what the elderly call ‘good carers’ (Bourgeault et al., 2010), especially if a ‘good carer’ is perceived as ‘patient, compassionate, and capable of responding to the needs of his/her clients’ (Bourgeault et al., 2009).

Perhaps a brief reference to a study by Schneider and Bowen (1995) on hotel front office staff can help illustrate this point. Their study of hotel frontline staff shows that the pressure that comes with servicing clients directly at the front desk emotionally impacts on the employees with fundamental implications for the way they serve the customers. Front desk personnel experience stress but are generally not expected or allowed to express negative emotions because of potentially detrimental impacts on the customers’ perceptions of quality service (Schneider and Bowen, 1995). Stressed front desk personnel are therefore still expected to
“act pleasant and courteous continuously even if they are actually miserable or dealing with a particularly nasty or ungrateful customer” (Schneider and Bowen, 1995, 110-111).

Ultimately, however, such environments tend to cause stress and research concurs that stressful events can result in negative behavioural and emotional reactions (Kahn and Byosiere, 1992). In this respect, Thoits (1984, 228) concludes that “be they mild or intense, these largely negative reactions are likely to be experienced as subjectively unpleasant”. Indeed an analogy can be drawn between direct care service work and hotel front desk work considering that these jobs are defined by largely by providing highly interactive services whose quality is defined by the way the provider looks, their tone of voice and other various intangible attitudinal dimensions of human behaviour.

### 3.7 Conclusion

This chapter has reviewed literature on the challenges faced by migrants in general and migrant careworkers in particular. Most of the studies have found evidence that support the view that most immigrants are vulnerable to discrimination at their work settings, have issues with allocated shifts, and tend to be allocated difficult tasks, clients and shits (Doyle and Timonen, 2009, McGregor, 2007). In the same vein, the reviewed literature agrees that that the employment of migrants has both costs and advantages to the organisation (Doyle and Timonen, 2009; McGregor, 2007). Another significant point emerging from this literature review is that the nature of carework can easily cause stress to the migrants. This is exacerbated by the fact that most migrants, as the profile of migrants provided in Chapter 1 showed, tend to be pushed out of their home environments by some unsavoury circumstances. All these reviews point to a dire need for some intervention strategies to be put in place to avoid compromising quality care delivery to the aged patients. This explains this study’s adoption of HRM as an appropriate theoretical framework to explore management approaches to the management of migrants in the quest to deliver quality care to the elderly.
Chapter 4: The study’s theoretical and conceptual framework

4.1 Introduction

The review of literature in previous chapters reflects a shared view of the major challenges that are associated with the employment of migrants. From a migrant worker perspective, the challenges they meet involve underemployment, poor remuneration, and potentially stress causing work-tasks and work environments. The previous chapters have also shown that there is a need to manage migrant employees in order to encourage behaviour patterns that are consistent with high quality care delivery. The literature suggests that it is important for managers to pay close attention to the intercultural care service relationships. In the view of this study, the nature of these challenges requires implementation of innovative HRM strategies. HRM is strategically positioned to play the intervening role in the management of the environment that the preceding reviewed chapters have identified as likely to interfere with the delivery of quality care by migrant carers. In the context of this study’s aim of exploring the implications of the increased participation of migrants as carers, this chapter presents HRM as a conceptual framework to further help inform the analyses and interpretation of the management of multicultural service provision environments, vis-à-vis quality care delivery.

4.2 Quality care delivery: The need for management interventions

The managers’ perceptions of the challenges migrants encounter at work will determine in some way the approaches they will take in mitigating those challenges. It is therefore important to briefly revisit some of these challenges that migrants are reported to face elsewhere since ordinarily, these are the challenges managers will have to deal with in their efforts to ensure quality care delivery by the workers.

Various studies concur that work environment factors such as lack of control over the job, high job demands, lack of support in work relationships, dealing with death and dying, being moved among different patient care units within the organization, shortage of essential resources, and excessive workload are commonly associated with role stress (Chang, et al., 2001; Lambert, Lambert, Itano, et al., 2004). In this regard, the previous chapters have already documented how some of the workplaces that the migrants find themselves at, are characterised by open and subtle discriminatory practices. Meyer, Schwartz and Frost (2008) found that workers who experienced racism risked experiencing high levels of stress and
subsequent physical and mental health problems. The literature reviewed has also highlighted that most migrants who take up the low job of carework suffer from various types of underemployment and have to deal with the repercussions of taking up a job that is generally lowly regarded. In the UK most carers are described as ‘British bottom cleaners’ (McGregor, 2007).

When these conditions that migrant carers face are added up, it seems more likely than not that they will negatively impact on their job performance. More importantly to this study is the argument that when workers encounter challenges at work, they may devise some coping strategies such as confrontation, withdrawal, and emotional distancing. These coping strategies are not in harmony with behaviour patterns that are consistent with intangible quality care delivery.

In this regard, the desire to avoid disruptions in quality care delivery supports the introduction of some forms of management interventions. The question therefore is: What kind of Employee Assistance Programmes (EAPs) can managers effect at their workplace in order to enable employees to deliver quality care?

In order to model the perceptions of managers regarding the implications of employing migrants, as well as the managers’ subsequent responses in ameliorating the challenges migrants face as discussed in the preceding paragraphs, this study draws inspiration from the conceptual framework of HRM. The implicit claim made about the value of HRM is that managers can adopt some innovative strategies and contribute to the delivery of quality care by implementing them in their interactions with migrant carers and other actors at their facilities. The strategic view of HRM that frames these strategies suggests that managers can contribute to the achievement of high quality care through effective utilization, and not exploitation of human resources.

4.3 Theories about human resource management

In order to understand the rationale behind the use of a human resource conceptual framework to enrich the study’s exploration of management perceptions of migrant worker’s experiences, in relation to the delivery of quality care by migrant carers, it is important to briefly explore the theoretical influences behind the approach which this study will adopt in its treatment of HRM. Research shows that there are basically three broad categories of general-level theories of HRM. These are strategic, descriptive and normative (Guest, 1997). Guest further argues
that strategic theories of HRM are mainly concerned with the relationship between a range of possible external contingencies and HRM policy and practice.

HRM policy and practice are therefore dependent variables, judged in terms of how well they fit the given context. The implicit claim made is that firms that have a good fit between business strategy, structure and HRM policy and practice will have superior performance (Miles and Snow, 1984). Guest (1997) criticises this theory arguing that “While the implication is that those firms achieving fit between business strategy and HRM strategy will have superior performance, they are weak in specifying the process whereby HRM is linked to performance” (265). He further criticises this theory for generally adopting a restricted view of performance, by defining it largely in financial terms.

However, the theory’s financially laden definition of performance does not seem in harmony with the management behaviour patterns that are required to guide employees to deliver care. Superior performance in aged care institutions may have to be defined largely by the ability of the firm’s workers to show genuine concern for the elderly patients’ demands for quality care, which is in most cases very intangible. Management strategies that can engender such qualitative behaviour patterns on the carers, are not in harmony with an organisation that views cost cutting as indicative of superior performance. It could be argued that the more the managers focus on the quantitative dimensions of performance, the less they are likely to bother themselves with the viewpoint of elderly patients regarding characterises of superior performance or quality care. The reviewed literature in the preceding chapters emphasised the need for management to be concerned about the human element and dimension of performance without disregarding the financial performance. However, because the financial orientation of this theory in it conceptualisation of superior performance, this study’s adoption of the HRM conceptual framework is not driven by this theoretical understanding of the field of HRM.

The second set of HRM theories are called normative. It is argued that normative theories of HRM tend to be more prescriptive in their approach, reflecting the view either that a sufficient body of knowledge exists to provide a basis for prescribed best practice or that a set of values indicates best practice (Guest, 1997; Walton, 1985). Although this theoretical approach to the application of HRM is persuasive, it has its own weaknesses. It is argued that its weakness is that it focuses predominantly on the internal characteristics of HRM at the expense of broader strategic issues (Becker and Gerhart, 1996; Dyer & Reeves, 1995; Guest, 1997). By being too
prescriptive and in advocating a best set of practices, these theoretical approaches to HRM may not capture some other important dynamic and contingent variables that impinge on business performance. These theories tend also to view the branches and goals of HRM as very defined yet, the list of HRM practices is far from clear (Guest, 1997; Dyer and Reeves, 1995; Becker and Gerhart, 1996).

The theoretical approaches to HRM that seem more useful to the concerns of this study are ‘descriptive theories’. These have largely been used by Beer et al., (1985) at Harvard University and Kochan, Katz and McKersie (1986). Although they are too general, they are more comprehensive in that they are open to the idea that there are numerous variables and interrelationships that impinge, for example, on the performance of a given organisation (Guest, 1997). These theories are inclined more with the approach that will be taken in adopting HRM as the conceptual framework of this study.

4.3 Human Resource Management: a conceptual framework

It is generally acknowledged that people are the greatest resource of any organisation (Armstrong, 2012; Storey, 1989, 2007). Without the right people in the right position, doing the right thing, no matter how well formulated the company strategy is, it is unlikely to succeed (Bratton and Gold, 2003). The HRM function, as the custodian of the people management processes, has grown significantly over time and now covers the whole range of people management processes.

In this regard, it is important to note that there are as many definitions of HRM as there are authors. It is argued that HRM has been exposed to considerable academic analysis but with little success in emerging with a “common agreement on what HRM means” (Heery and Noon, 2001, 61). HRM can however be defined as a “strategic and coherent approach to the management of an organization’s most valued assets – the people working there, who individually and collectively contribute to the achievement of its objectives” (Armstrong, 2008, 6). In the same vein, Boxall, Purcell, & Wright et al., (2007) argue that HRM involves managing work and people to achieve set goals whilst Lado and Wilson (1994) define HRM as a set of distinctive activities, functions and processes that are targeted at attracting, directing and maintaining an organization’s human resources. In other circles, HRM has been described a “set of interrelated policies with an ideological and philosophical underpinning” (Storey, 1989). Storey further argues that HRM is defined by four aspects which are: specific
collection of beliefs and assumptions; 2) a strategic thrust informing decisions about how to manage people, 3) the fundamental role of line managers; and 4) reliance upon a set of ‘levers’ to shape the employment relationship.

According to Bratton and Gold (2003) HRM is “a strategic approach to managing employment relations which emphasizes that leveraging people’s capabilities is critical in achieving competitive advantage”. This is an especially interesting definition in the context of this study’s concern about understanding the perceptions of managers of aged care facilities regarding the employment of migrants as careworkers, and what the managers perceive as integral in leveraging the capabilities of migrant carers to achieve the organisational objective of quality care delivery to the elderly patients.

Despite the existence of such diverse definitions, most writers in the HRM field agree that there are four generic HRM processes or functions that are performed in all organizations. These are recruitment and selection, performance management; reward management, and human resource development (Shen and Edwards, 2006) and they are all tied to job performance. It is argued for example, that HR professionals and managers who recruit and interview job seekers in a multicultural workforce, need to pay attention to the various ways in which both the interviewee’s and interviewer’s beliefs, attitudes, and stereotypes may impact on work relationships as well, and ultimately on their job performance. These building blocks of HRM are succinctly captured in the form of a cycle as indicated (Figure 4.1).

![Figure 4.1: The human resource cycle](image)

Source: Fombrun, Tichy and Devanna, 1984 cited in Armstrong, 2008, 5)
Figure 4.1 above captures what could be argued as being the essence of HRM. However, it is important to note that this reductionist approach to HRM may be criticised for being too simplistic as well as being too prescriptive since HRM is such an expansive field that cannot be reduced to these five elements.

On the other hand, this weakness of being too simplistic could also be viewed as its advantage. This is because, from a pragmatic perspective, the five elements could be considered as indeed the building blocks of HRM. They are also broad to the extent that other emergent variables can be captured within the relevant elements of the model. In the context of aged care facilities management, this HR cycle dramatizes the major functions they have to perform. For example, they have to recruit and select carers. In light of the previous literature that documented the increased participation of migrant carers in the aged care sector, this model reinforces the idea that the selection and recruitment function is of great significance since it is intertwined with the desired output of quality care and happy elderly patients. The performance of the recruited workers vis-à-vis provision of quality care is also intricately intertwined with other HR functions such as the compensation levels and the attention given to the training and development of employees.

However a more comprehensive view of HRM is captured in Figure 4.2 which depicts the Harvard Framework for Human Resource Management (HFFHRM). The Harvard Framework proposes the main resource policy areas that define a major HRM task that general managers must attend to, depend on the nature of the organisation. These are employee influence, human resource flow, reward systems and work systems (Beer et al., 1985). Although the model below ca also be criticised for being too general, it is nevertheless appealing because it is less prescriptive.
Figure 4.2: The Harvard framework for human resource management


With reference to this model, Boxall (1992), also argues that it is more comprehensive in that it recognises the diverse range of stakeholder interests; explicitly and implicitly captures the idea of ‘trade-offs’ between the owners’ and employees’ interests; and offers a wider context of HRM that includes ‘employee influence’, the organization of work, and the associated question of supervisory style. Boxall (1992) also argues that this model acknowledges a broad range of contextual influences on management’s choice of strategy, suggesting interconnections between both product-market and socio-cultural factors.

The HFFHRM provides a more holistic perspective of the building blocks of HRM practices. Within the Harvard Framework is the idea that Human Resources should cease being viewed as a cost to be minimised, but be conceptualised as a strategic tool that can help the organisation to meet its goals and remain competitive in the market. This human dimension that pervades the HFFHRM is appealing to this study that is concerned about how humans take care of others in a social, as well as a business environment.
A very significant point to note about this HFFHRM is that it inspired by studies in business strategy that show that HR can play a prominent role in generating sustained competitive advantage (Becker and Gerhart, 1996). According to the resource-based view of the firm (Barney, 1995), firms can develop sustained competitive advantage only by creating value in a way that is rare and difficult for competitors to imitate. Traditionally, sources of competitive advantage have been seen as natural resources, technology, economies of scale. The resource-based argument is that these sources are increasingly easy to imitate, especially in comparison to a complex social structure such as an employment system. To create value many firms are looking at ways in which their service delivery can become a source of sustainable competitive advantage. Firms can therefore not remain ahead of the competition through its material resources.

Real sustainable competitive advantage can only be achieved through the manner in which a firm makes use of its human resource. This is an especially attractive argument from the viewpoint of the manner in which elderly patients define quality care as was discussed in Chapter 2. The aged care facility can have state of the art hoist machines, modern vehicles for recreational activities as well as modern furnishings, but it can be argued that any aged care facility can possess such equipment. However, the possession of such facilities and equipment may not necessarily confer an aged care facility with sustainable competitive advantage. The view of human resources as a strategic arm of the firm therefore questions the extent to which these facilities will enable a firm to remain ahead of the competition. One of the most significant arguments embedded within the Harvard approach is that the new competitive environment necessitates a more strategic and resolute approach to personnel management, with implications for personnel departments, line managers and corporate strategies (Druker White, Hegewisch & Mayne, 1996). This approach recognises that people are key to the competitive advantage that a firm can ever have over others.

It is important to briefly emphasise that aged care facilities operate like any other For-Profit organisation. Even those that claim to be Not-For-Profit, they still need to attract enough residents that will enable them to break even. Just like the For-Profit driven, the Not-For-Profit also need to create a good name for themselves so that family members can bring those that require aged care services to their facilities. An aged care facility that generates a lot of bad publicity in the national and local newspapers is unlikely to attract more residents.
Ultimately without residents, there institution will have to shut down. This underlines the critical role of HRM as “a distinctive approach to employment management which seeks to achieve competitive advantage through the strategic deployment of a highly committed and capable workforce, using an integrated array of cultural, structural and personnel techniques” (Storey, 1995, 5). At one end of the scale of structures that can be used by managers is the mechanistic structure which is characterized by rigid task definition, vertical communication, and high degrees of formalization, authority-based influence, and centralized control. On the other end is the organic management structure which is characterized by flexible task definition, lateral communication, low degrees of formalization, decentralized control, simple differentiation, among other distinguishing variables.

4.4 Some HR areas of concern

In light of earlier discussions about how the elderly patients define quality care, it can be argued that an aged care facility that desires to attract many residents to its facility in a sustainable fashion will have to appear different on the basis of how it uses the state of the art facilities at its disposal. The state of the art facilities do not necessarily provide the competitive edge, but the manner in which HR uses the facilities does. In short, this means that the difference in quality is noticeable at the level of attitude and behaviour patterns shown by the workers. The earlier discussion on the challenges migrant workers meet at the workplace suggests that management, or the HR function, has a lot to do in order to manage the diverse variables that may impact on the manner in which the workers discharge their duties. Some studies have in this respect identified the various dimensions of HR that can help an organisation to make sustainable profits (Bach, 2000).
These elements by Pfeffer (1998) capture some major dimensions that the preceding reviewed literature highlighted as areas of concern in the management of migrant carers to deliver quality care. Some of these dimensions, such as item 7 above, may not be obviously applicable, but the rest of the dimensions are very relevant to the management of aged care facilities in the context of improving the performance of migrant workers to enable high quality care delivery. The selection and recruitment of migrant carers, their compensation and training, as well as the identification and reduction of barriers that they face in their day to day performance, are all very important areas of concern for aged care facilities.

Chapter 2 dealt extensively with the conflicts arising from the convergence of diverse cultures in aged care facilities and the resultant pressure on the service encounters.

In this respect various studies have identified diverse skills that are deemed critical if a manager is to be effective in a cross-cultural setting. Although these skills are designed with an expatriate manager operating in a foreign setting in mind, they are still useful for managers of migrant workers because they deal with largely similar issues. Mendenhall and Oddou (1985; 1991) categorised these critical skills into three dimensions:

Figure 4.3: HRM critical success factors

(1) the self-dimension, which encompasses skills that enable the expatriate to maintain mental health, psychological well-being, self-efficacy, and effective stress management;

(2) the relationship dimension, which constitutes the range of skills necessary for the fostering of relationships with host nationals;

and (3) the perception dimension, which involves the cognitive abilities that enable the expatriate to correctly perceive and evaluate the host environment and its actors (Black, Mendenhall, Oddou, 1991, 295).

The managers’ actions to engender such skills become even more relevant when considered from the viewpoint of challenges of providing quality care to the elderly. It has been observed, for example that:

“Many older persons are vulnerable to poor care quality and care fragmentation. Without processes in place to ensure the delivery of high-quality care, the health of countless older adults will continue to be compromised. Such high quality processes are not limited to the realms of administration; they must be enacted among those providing direct care to patients. Furthermore, it is argued that effective care processes should incorporate and reflect individualized patient needs, preferences, and cultures” (Dilworth-Anderson and Palmer 2011, 9).

The above characterisation of elderly patients and their quality care requirements suggest that there are many challenges that interfere with the process of managing care institutions vis-à-vis delivery of quality care. Quality care delivery is dependent upon the actions of various actors such as administration or management staff, carers and the cared for. The role that managers play is dependent on their perceptions of the impact of various factors that they deem as having a crucial moderating effect on the performance of their employees. This suggests that the management of such institutions need to develop and exhibit a unique set of skills to deal effectively with the challenges brought about by the coming together of all these variables.

Earlier reviewed literature recorded various grievances from migrants’ complaining about few shifts, low pay, or being assigned too many tasks in a short period of time, and still being expected to perform (Bourgeault, 2010; Spencer, 2010; Walsh and O’Shea, 2009). The prevalence of these complaints suggests that there is a gap that needs to be addressed in the
management strategies that are being employed to guarantee quality care delivery in aged care institutions in the context of migrant careworkers. It is important to note that the problem of few shifts may also be a concern for indigenous workers. However, also important is the fact that some migrant carers have been cited as being of the view that the few shifts that they are allocated to by their managers are a reflection of discriminatory tendencies. Whilst this view may be true or false, it is also important to note that it is this perception that ultimately influences how the migrants deliver care. Their perceptions, whether based on reality or not, are the reality that they use to shape their behaviour patterns. It could therefore be argued that if the migrant workers’ perceptions of discrimination or favouritism in allocation of shifts is wrong, it can still be considered a negative indictment on the managers since it reflects them as having failed, perhaps, to provide adequate information to those that need it or to act in a manner that does not suggest they practice racism or discrimination.

In light of the central role that this study ascribes to HRM regarding the management strategies that can be deployed to reduce the occurrences of such complaints, it seems prudent that the following sections explore some HRM dimensions that may be suited to the management of migrants carers, vis-à-vis, quality care delivery. In this regard, various studies distinguish between ‘hard’ and ‘soft’ versions of HRM, suffice to say that most of the complaints from migrants, as discussed in the previous chapters, reinforce the point that soft or human HR skills are more important to the successful management of migrant carers for enhanced care delivery. Carework is largely about caring for the needs of the elderly and therefore explains the focus of a behavioural perspective of HRM, as well as organic management, in this study as way of generating behaviour patterns among the workers that are consistent with quality care as it is defined and conceptualised by the recipients: the elderly patients. This also suggests that behaviour modelling should be a central concern of managers of facilities that deliver intangible and tangible services. This is because behaviour modelling is perceived to be able to help employees to choose the right behaviour attributes to express according to a specific work situation (Andersen, 1995). The question becomes, how do managers of elderly care facilities manage the behaviour of their migrant workers? It will also be interesting to explore the perceptions of the managers regarding whether these will be different from their domestically sourced workers?

It is therefore in this context that the following sections explore the concepts of ‘Hard vs. Soft HRM’ (Druker et al., 1996; Storey 1989).
4.5 Hard vs. soft HRM

The significance of these two HRM perspectives has to be considered from the viewpoint of his study’s concerns: management’s perceptions, migrant carers and quality care delivery. Complaints from migrant carers as recorded by Cangiano et al., (2010) support the conclusion that most aged care facilities have failed to create a balance between hard and soft perspectives of HRM. Storey (1989) distinguished between ‘hard’ and ‘soft’ forms of HR and notes that there is a tendency within hard HR to replace ‘people’ with ‘employee’. It is also argued that the ‘hard’ version adopts an instrumental and economically rational approach to HRM (Storey, 1989; 1992). In this view, it is argued that people management strategies are driven by strategic considerations to gain competitive advantage, maximizing control while achieving the lowest possible labour cost (Storey, 1989). In the same vein, Drucker et al., (1996) noted that the hard HR approach puts a lot of emphasis on strategic business objectives, and treats human resources’ like any other factor of production without according it a priori central status in achieving competitive advantage. The hard HR approach is therefore largely quantitative and calculative and views labour as a commodity/resource, the same as any other. The hard approach tends therefore to be more concerned about the costs that are incurred by the organisation and not the people working for the organisation.

The faults embedded in the hard HRM approach emerge especially when considered from the perspective of the worker-behaviour attributes that are consistent with the delivery of quality care. The description of carework in Chapter 2 as intangible and requiring soft human skills for its successful delivery, magnifies the error and futility of adopting ‘hard’ HRM approaches to engender, qualities of compassion, patience, love, care, and generosity that the elderly look for in their carer.

Given these qualities that the elderly look for in their carer, it can be argued that the soft version of HRM is more fitting in that it encourages the adoption of a humanistic and developmental approach to the management of people. The soft HR with its focus on ‘internal customer satisfaction’ (Industrial Relations Services, 1998, 86) or the ‘human element’ is more consistent with the approach needed by HR to engender and cultivate behavioural qualities in its workers that can support delivery of intangible quality care.

A soft HR approach is generally viewed as more consensual and based on a high level of managerial commitment to employees, which is intended to lead to mutual high commitment, high trust, and high productivity (Karami, Analoui, & Cusworth, 2004). The soft HRM view
approach is underpinned by a philosophical belief that employees are proactive, capable of being developed and worthy of trust and collaboration.

It is argued that ‘good’ HRM determines performance and motivation (Buchan, 2004). In this regard, it is argued that work conditions constitute an important motivational determinant. Comprehensive HRM therefore also needs to look at and optimize work conditions. Kanfer (1999) identifies an aspect of the internal motivation process: the ‘will-do’. This aspect concerns the establishment of congruence between personal goals and the goals of the organization (goal setting). Questions that characterize this psychological process are: “What is the personal value of devoting more of my resources to the job?” or “What is the personal value of achieving higher job performance?”

All these question are very relevant to the migrant carer who, as was established earlier, tends to be overqualified for the job they are doing and might also perceive discrimination and racism from managers, co-workers, and family relations of the patients. This suggests that the management’s role is indispensable to the manner in which the migrant carer is going to discharge of their duties. Complaints from migrant carers as recorded by Cangiano et al, (2009) suggest that most aged care facilities have failed to create a balance between hard and soft perspectives of HRM.

4.6. Training and professional development opportunities

In light of the profile of the migrant worker as described in Chapter 1 and 2, in light of the problems that they face elsewhere as the previous chapters have shown, and in the context of the hard nature of the carework job, the study now explores some critical HRM areas that can enrich the exploration of the management’s perceptions about what need to be put in place, to ensure quality care delivery by, the migrant careworkers. The first of these HRM areas is connected to the profile of migrants as underemployed people who may need to develop new skills in order for them to feel recognised in their roles. Although some studies argue that the provision of training may not necessarily be enough to improve the quality of care (Wanless 2006), the importance of training cannot be overemphasised. Training can accomplish a number of objectives. For instance, the provision of training can be seen as a form of support that is provided to the carers so that they can perform well in the jobs.

The creation of such a supportive work environment is particularly important for care assistants and related staff in light of the fact that they provide the majority of the ‘hands on’
In the context of migrants, it has been observed that although unsatisfactory first jobs in new countries such as carework can function positively as ‘stepping stones’ during a period of acculturation, these jobs can also function negatively as ‘entrapments’, especially in situations where there is underinvestment in training or language, as these have been shown to prevent workers from moving onwards and upwards (William, 2007). In the UK, although training has been identified as an important way of improving recruitment and retention of migrant workers and of ensuring that they have the skills to meet the future demands of their role, the migrant workers’ access to training has not drastically improved (Cangiano et al., 2009).

Many studies suggest that best practice in recruitment, selection, training, orientation and induction can go a long way in facilitating the new migrant to fit into the new place, and to quickly develop some connection to their job. In this respect research by Hussein, Manthorpe & Stevens (2011b, 487) showed that 28% of migrant social worker participants had not received any induction, training and preparation when starting their current social care work in the UK. Most of the interviewed migrants also felt that the induction programme did not contain very useful content. Of those who had received induction in their current jobs, they indicated “in the free text that their first jobs in the UK usually came with no induction at all” (Hussein, et al., 2011b, 489). The same study discovered that most migrants expected the induction process to be provided by ‘key’ people that were able to also provide on-going support. Another important finding was that the migrants considered the pace and content of the induction programme to be important. Migrants also felt that the content of induction should cover cultural differences and practical advice and training (Hussein et al., 2011b).

It is important to note that very little concerted effort has been put into exploring the perspectives of management regarding these issues. This study hopes therefore to play its part in developing this area.

**4.6.1 Diversity management skills**

Another important training area of concern, especially given the internationalized nature of most employment profiles, is the need for diversity training on the part of managers. Diversity training is a must for elderly care institution managers especially because of the increased participation of migrants in the care of the elderly. Stone & Bryant (2011) argue that in light of the diversity of this workforce, communication issues, the manner in which various
cultures differ with respect to caregiving, can be challenging. In their research, Stone & Bryant (2011) also note that:

All staff, residents/clients, and families need to have a better understanding of the cultural nuances that are associated with delivering person care across all settings. It is essential that training and educational materials, and the organizations or individuals who employ direct care workers, recognize and address the unique racial and cultural issues that are often barriers to a healthy work environment, including good communication, problem solving, and ultimately, provision of timely and quality services (p.170).

Besides focussing on a diverse range of HR issues such as recruitment and selection, and performance appraisal, this diversity training may have to give prominence to cultural awareness training. In this regard, Parker and Geron (2007) argue that English as a second language should be seen as only one of the cultural competence issues that have to be addressed. The literature on training direct care workers in long-term care, and on reducing burden in family caregivers, such as Hoffman, 2003; and Schulz et al., 2003, emphasise the need to train careworkers in communication; interpersonal relations, so that they can efficiently deal with differences and resolve conflict. The earlier discussion about service relationships and service encounter management in an intercultural context suggests that training is central to the development of soft HR skills that are integral to the delivery of quality aged care.

An important point to also note about the training is the manner of delivery of the material especially in light of the behavioural changes that need to be seen and acted out by the care worker. Studies recommend that the curriculum has to contain active-learning activities, including experiential exercises, role playing, debate, self-assessment inventories, video viewing, demonstrations, short writing assignments, case studies, small group work, storytelling, and discussion (Braun, Cheang, & Shigeta, 2005). The training must in essence accord the participants ample opportunities to tell their stories and share their personal accounts and challenges as a way of making sense of their work experiences.

In this context, Braun et al., (2005) give an example in which, during training, a direct care worker shared her annoyance with a dementia client who asked the same question over and over again. This provided a teaching moment in that the carer was advised to separate the
person from the disease (dementia). The trainee therefore gained critical knowledge that helped him to differentiate the disease from the person. In fact the disease was the source of annoyance and not the character of the client. In the practice of his daily duties and physical interactions with the client, this newly acquired knowledge should help him to look at the ‘annoying event’ differently and perhaps even continue to be patient and nice to the ‘annoying client’. In the same context, a care worker who attended this training reported that they had used their newly acquired skills and knowledge to persuade an elder who had resisted taking regular showers, whilst another carer used the new skills to encourage a client into increasing her intake of nutritious foods (Braun et al., 2005).

A significant point to note here is that ordinarily, these carers would not have invested their time and patience, nor would they have had developed this sense of responsibility and care and compassion to persuade the elder clients to change their behaviour patterns. Training is therefore important for both managers and employees. The question arising here could be what form of training should management expose their migrant cohort of employees to? What is the content of the training material and how should it be delivered?

Professional development and career planning is another area where discrimination is visible and needs careful attention while designing diversity management policies. Research elsewhere underlined the value of training alongside daily care responsibilities giving weight to Burris’ (1983) assertion that the ‘opportunity to grow’ can mitigate subjective forms of underemployment. Negativity might be engendered if HR practices concerning career progression do not effectively reflect diverse interests of employees (Richard & Kirby 1999). Organizations should ensure they provide equal opportunities for promotion and personal development to all employees.

Nevertheless, there are also some who view diversity management as integral to the maintenance of a high performance work environment. It is argued for example that staff management practices that address the different needs of employees from different culture groups will result in lower HR costs (Dawson & Surpin, 2001; Fastenau, 2008, cited in Stone, 2008). High turnover also may lead to disruptions in continuity of care for residents and clients (Dawson & Surpin, 2001) and poor quality of care (Castle & Engberg, 2005). High turnover can be costly to consumers (Dawson & Surpin, 2001), workers (Mickus, Luz, & Hogan, 2004), and providers (Seavey, 2004).
Questions may be raised as to the implications to quality care delivery in situations where a manager who shares negative stereotypes of migrants is not exposed to some form of diversity training. What can HRM do to avoid a situation where the prejudices and misconceptions held by an aged care facility manager against a migrant careworker, due to the careworker’s cultural background, skin colour, language or national identity, interferes with the managers’ ability to genuinely deal with the concerns that the migrant worker brings to the manager for resolution?

This discussion is important in that it highlights the dangers to the integrity of an organisation that is managed by a manager who shares various negative stereotypes of other races. In light of the increasing number of minority careworkers and patients, some studies have argued that the provision of a culturally competent carer is a key strategy for reducing racial and ethnic health disparities (Brach & Fraserirector, 2000; Institute of Medicine, 2004; Shaw, 2005).

In this regard, it will be interesting to explore the views of aged care facilities regarding the management qualities they consider integral to ensure that aged care facilities deliver care in the backdrop of increasingly diversified workplaces.

It is however, important to note that the concept of diversity management has its own weaknesses. In fact, actual practice shows that “there is no ‘one best way’ to manage diversity: no simple list of ‘do’s’ and ‘don’ts’ can be generated that will tell managers how to manage every circumstance…” presented by diversity among employees (Sayers, 2008, 84). The long term impact on people’s basic attitudes and values of diversity management has also been questioned. For example diversity management is derisively viewed as a “politically correct” programme that can only “aggravate existing barriers” (Mathis and Jackson, 2004, 348).

In this respect, Fasteneau (2008) identifies three approaches to managing diversity: anti-discrimination or equal employment opportunity; affirmative action; and diversity management. Fasteneau (2008) notes that these approaches facilitate equitable employment opportunities for all employees. It has been observed that many migrants have difficulties convincing themselves to apply for higher level positions in the organisation because their perceptions are that they stand little chance of being hired. For example, Pendakur and Pendakur (2006) found evidence that support the position that disadvantaged workers face a
glass ceiling: a barrier that limits access to high-wage jobs or, the “invisible barrier that stops minorities from applying for senior positions or moving across functions in an organisation” (Stone, 2008, 219). A manager who visibly and genuinely subscribes to equal opportunity employment (EEO), might perhaps exhibit some behavioural characteristics that can help break this ‘glass ceiling’. In this regard, it has been observed that cultural biases of managers can restrict people from non-English–speaking backgrounds to enter management positions (Weinstein, Curran, & Tomlinson-Clarke (2003).

4.7 HRM and job design: towards an empowered carer

It is generally agreed that better management practices, implemented as part of a broader organizational ‘culture change’, can improve the quality of the jobs, reduce turnover, and ultimately improve the quality of care provided (Stone, Dawson et al., 2004). The soft HR approach is suited to help workers to fit with, or to adopt a new organisational culture. In the USA various workforce initiatives have sought to improve the jobs of direct care workers in long-term care. One of these initiatives was the Better Jobs Better Care (BJBC) demonstration (Brannon, Barry, Kemper, Schreiner, & Vasey, 2007). The BJBC, which was designed to test innovative policies and management practices intended to improve the quality of direct care jobs and improve recruitment and retention of direct care workers (Kemper et al., 2008).

Careworkers’ complaints about job ambiguity, perceived racism and discrimination, among other concerns (McGregor, 2007), suggest that more vigorous interventions may be needed, such as orientation and mentoring. Studies have shown that the right amount of challenges and pressure in a job keeps workers motivated and gives them a sense of ambition and self-esteem (ACAS, no date). Employees however do not enjoy being overloaded, nor do they like to be asked to do a lot of tasks in limited time (ACAS, no date). This suggest that management has to be innovative in job design.

Job design is about the way a job fits into the wider picture: how it contributes to producing a product or service, how it is linked to other jobs and the variety, pace and nature of the work itself (ACAS, no date). Although it is rare for jobs to be designed to incorporate all the vital characteristics, there are some major ones that may be applicable to a migrant worker who is in a job that may never have featured in their dreams before, until the traumatic events in their home bases forced them out. Most studies concur that jobs must form a coherent whole either
independently or with related jobs, and the performance of the job (or jobs) should make a significant contribution to the completion of the product or service (ACAS, no date).

Research by Mittal et al., (2009) discovered that most carers viewed ‘job crafting and flexibility’ as critical factors in their decision to stay or leave the care work job. Many of the interviewed carers cited the discretion and flexibility the job gave them, as attractive. The carers revealed that although they had many responsibilities at work, management did not closely monitor them during the performance of their tasks. This opportunity to craft their tasks and even modify their jobs enabled them to provide better care for their residents, and in turn feel in control (Mittal et al., 2009).

Besides offering opportunities to the carer to assume some responsibility for outcome, job design should ensure the structuring of tasks that provide some variety of pace, method, location and skill, as well as some discretion and control in the timing, sequence and pace of work efforts (ACAS, no date). In the same vein, in their evaluation of the Wellspring nursing home quality improvement programme, Stone et al., (2002) found that the empowerment of the careworkers, through facilitating their participation in care planning and care plan implementation, impacted positively on turnover, as well as a reduction in health deficiency citations from state health inspectors.

This discussion on job design has to be understood from the perspective of research on migrant care workers that recorded complaints from migrant careworkers about the carework job as being characterised by limited opportunities to take responsibility, limited opportunities for personal development, as well as the performance of tedious and repetitive tasks (IOM, 2010). The literature reviewed in Chapter 3 also highlighted that most employees had problems with the tasks they were asked to perform. They complained about being asked to do a lot with minimal resources and sometimes being mismatched with the tasks. In this regard, it can be argued that there is a need for unit managers to craft strategies to help the overwhelmed migrant worker. Brannon, Barry, Kemper, Schreiner, and Vasey (2007, 28) argue that “strategies for enhancing the value of helping others might include stable assignments that encourage relationships, thoughtful matching of clients and caregivers, rewards and recognition, and training and care planning participation that broaden the scope of helping opportunities”.

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4.8 Compensation management

Pay equality is also another important SHRM objective. It has been argued that pay equality contributes to effective diversity management and organizational performance. Empirical evidence suggests that the compensation structure, the wage determinants and the benefit schemes should be designed not only on common principles, but also considering individuals in terms of their ability, knowledge and skill. An individual-driven remuneration system facilitates individual lifestyles and further promotes diversity (Friedman and Holtom 2002; Kramar 1998). Research on migrant care employment generally agrees that the sector is characterised by low pay level, tedious and repetitive tasks that are generally unrewarding, unchallenging and lowly paid.

4.9 HRM supportive role: controlling the severity of work environment stressors

In light of literature perspectives on carework as a difficult job, questions may be raised about the role HRM can play to mitigate the severity of the care job conditions. Carework itself is generally tedious and repetitive and the general working conditions in elderly care facilities tend to be of a strenuous nature as they involve extended periods of standing, walking, and lifting the aged, who in some cases can barely do anything on their own. This heavy workload is exacerbated by high levels of risk to personal health associated with the process of providing personal care to the aged, some of whom suffer from terminal and contagious ailments. In addition, most care work involves extended contact with water, cleansing products and gloves which may all present health challenges to the carer.

The literature reviewed in the previous chapters suggest that nurses who are often confronted with high physical job demands and have low physical job resources are at risk for physical complaints and burnout. Enhancing specific job resources, such as the availability of well-designed ergonomic aids, enables nurses to deal with their high physical job demands. In turn, these self-regulatory processes should result in reduced physical complaints and burnout (Lundstrom, Pugliese, Bartley, Cox, and Guither, 2002). It is the duty of the management function to create a work environment in which the worker feels safe. In this respect, a study by Gershon et al., (2000) identified a variety of factors at an organisational level that define a ‘safe hospital climate’. These are senior management support for safety programmes; absence of workplace barriers to safe work practices; cleanliness and orderliness of the worksite; minimal conflict and good communication among staff members; frequent safety-related
feedback/training by supervisors; and availability of personal protective equipment and engineering controls.

In the case of direct care workers, migrant or not, they have regular and on-going contact with vulnerable adults, providing personal and sometimes intimate care, often without direct supervision (Applebaum & Phillips, 1990). They are relied on to notice and report changes in health, behaviour, and functioning; to handle challenging clients and families; and to solve problems (Harmuth, 2002). Like family caregivers, direct care workers may experience burden and burnout, with negative consequences for elders under their care. Providing direct care to vulnerable elders is a demanding job. In this context, the HRM function can also play an important role in the promotion of help-seeking behaviour among new employees.

In a discussion on management of depression at work, Martin (2010) argues that the way in which managers handle these processes can directly affect both the employee and the organization. Martin argues that the managers’ negative attitudes may impact on employees by “creating a barrier to accessing support and a non-discriminative approach to managing the employment related aspects of the condition” (Martin, 2010, 1). In Martin’s view, positive attitudes of managers can impact on the organization by minimizing avoidable absences or high turnover, discrimination claims, and disruptions to team work. Martin suggests that in order to manage depression at work for example, the manager can aggressively promote help-seeking among the depressed employees.

Most studies agree that burnout can result in reduced job performance (Halbesleben & Buckley, 2004; Maslach, Schaufeli, & Leiter 2001). It is well documented that those suffering from burnout tend to be less productive and effective (Korunka, Tement, Zdrehus, and Borza, 2008) and are more likely to ‘start conflicts with colleagues and disrupt joint work tasks’ (Korunka et al., 2008, 17; Maslach & Leiter, 1997). Besides showing higher intentions to leave the job, they also tend to act in ways that show a lack of organizational commitment (Bakker, Demerouti & Verbeke, 2004; Korunka et al., 2008). It is also argued that burnout can be ‘contagious’, and can lead to higher costs and financial losses because of higher absenteeism rates and more frequent sick leaves (Halbesleben & Buckley, 2004; Maslach and Leiter, 1997). Although most of these issues are pertinent to all types of carers, they assume greater significance when considered form the viewpoint of migrants who, in light of previous discussions about how they find themselves doing carework, may lack the commitment necessary to achieve high quality care delivery levels.
In light of this discussion, some pertinent questions arise relating to the position of management about their views on the subject of training for managers themselves. Does management conceive training as integral to their ability to manage a facility that has an international cohort of employees? What are the views of management regarding the content of such a training programme? What is the training likely to achieve in the management of the migrant workers?

4.10 Emerging research questions

A close analysis of Chapters 1 to 4 raises fundamental intertwined themes that need academic inquiry. In Chapter 1 the study spelt out some critical issues about the population age structure changes and the resultant pressure on health care systems. Whilst the demand for aged care is rising, the labour supply, especially with regard to indigenous workers, has not responded proportionately. The strategic response for most of the Western industrialised aged care countries has been to turn to migrants. The labour supply shortages in light of the increased number of the aged needing institutionalised aged care, brought into the picture the role of the migrant carers. An important issue with regards to the typology of these migrants was that most of them were in that situation because of both ‘pull and push’ factors. The chapter ended by noting that extant research in New Zealand had not adequately explored the migrant phenomenon in relation to the quality of care provided to the elderly.

Chapter 2 provided detailed conceptual analyses of ‘care’ emphasising its elusiveness. Some significant issues pertinent to this study were identified. For example, the chapter established how elderly patients characterise quality care. Subsequently, the chapter raised the issue of the impact of migrants’ participation on quality care delivery in line with the elderly’s definition of quality care. The chapter noted that migrants have their own cultural definitions and conceptualisation of quality care which may or may not be in harmony with the perspectives of the carees. The role of migrants has magnified the question of cross-cultural expectations and pressures in the delivery of quality care to the elderly. To this end, the migrant variable came across as having the potential to cause serious negative impacts to the delivery of quality care especially if no intervention strategies are put into place. This in turn, highlighted the importance of finding out the perceptions of managers about how best to manage the interactions of these diverse variables in the quest for quality care delivery. In this regard, Chapter 2 put the managers of aged care facilities at the centre of this problem by asking the question: ‘What role do managers play in the management of service encounters in light of the
intercultural dimension that these encounters are increasingly taking due to the participation of the migrants in elder care provision?'.

Chapter 3 developed this intercultural service encounter management theme by providing an elaborate discussion of the challenges migrant carers face elsewhere. It was noted that migrants encounter a variety of challenges such as perceived racism and discrimination at the work place among other many problems. The exploration of these challenges served in part to highlight the important role managers have to play to ensure quality care delivery in a multicultural service delivery environment. A significant underlying theme that ran through Chapters 1-3 was the central role that human resources play in making a difference at the work place. The definition of quality care by migrants put the role of people at the centre of the quality care delivery.

It is this context that Chapter 4 focussed on the role of human resources by adopting a Human Resource Management theoretical framework. Fundamental to the exploration of HRM was that sustainable competitive advantage is more achievable through innovative utilisation not exploitation, of the human resources. This is especially an important point in light of issues covered in Chapter 3, that presented migrants carers as operating in largely hostile environments in which there is perceived discrimination and racism among other perceived unfair practices. In light of the description of carework in Chapter 2 as intangible and requiring soft human skills for its successful delivery, the exploration of diverse HRM approaches in Chapter 4 emerged with a view that was inclined more to the adoption of a strategic ‘soft HRM’ perspective in the management of aged care facilities, with a view to ensuring quality care delivery by migrant carers. Soft HRM appear more capable of engendering in the carer qualities of compassion, patience, love, care, and generosity that the elderly look for in their carer.

By way of summary the literature explored so far suggest that, given the nature of challenges migrant carers face elsewhere, determining the levels of awareness on the part of managers about the challenges their migrant cohort of employees face, will go a long way in shaping the strategies to be deployed to mitigate these challenges vis-à-vis quality care delivery. The literature also suggests that managers that have a low level of awareness of the range of challenges that migrants in general and migrants carers face elsewhere, as shown in Chapter 3, and are unlikely to concern themselves with the crafting of a strategy to deal with ‘non-existent problems’.
In this regard, from an academic inquiry perspective, this study seeks to investigate the views of management of aged care facilities that employ migrant carers, regarding the support that they consider important in building positive and rewarding patterns of intercultural service relationships between the careworker and the elderly patients as well as the other elements in the environment such as co-workers, family relations of the elderly, and managers themselves.

This study therefore explores the following three broad issues, from the viewpoint of management of aged care facilities:

1) What are the characteristics of the migrant care workforce and how do these impact on the delivery of quality care at the required quality levels?

2) What are the managers’ perceptions about the challenges presented by these characteristics?

3) What are the HR coping strategies that have been applied by management to deal with any identified challenges?

4.11 Conclusion

The chapter has presented HRM as the conceptual framework modelling the exploration of the perceptions of managers of aged care institutions about the experiences of migrant carers vis-à-vis quality care delivery, as well as possible management intervention strategies. The strategic perspective of HRM is very useful because it implies that there are management strategies that can be crafted to help the organisation make use of its human resources in a manner that is going to enhance achievement of organisational goals, such as high quality care delivery, which in turn may guarantee sustainability of the organisation.
Chapter 5: Methodology

5.1 Introduction

This chapter presents the methods that were used for the purposes of achieving this study’s objectives. Central to this study is the quest to unravel the perceptions of managers regarding the increased participation of migrants as carers vis-à-vis quality care delivery. The study of perceptions raises some ontological and epistemological questions. In this regard a perceptions study implies an exploration of how managers interact with their migrant carers.

In this regard, Gestalt social psychologist Solomon Asch’s (1952) views are very insightful. Asch (1952) observed that “the paramount fact about social interaction is that the participants stand on common ground, that they turn toward one another, that their acts interpenetrate and therefore regulate each other” (p. 161). There is therefore reciprocity of perception and action.

From the perspective of this study, Asch’s (1952) statement above raises some fundamental issues. For example, it raises questions about what the managers, migrant carers, indigenous carers, family relations of the aged have in common. What is it that they understand about other each other and about themselves in regarding the caring of the elderly? How does this understanding arise and develop? In relation to quality care delivery, does this understanding enhance quality delivery or it is a distraction? All these questions bring to the fore, the intercultural dimension within which the perceptions and actions take place. To customise Lave’s (1988) argument, it can be argued that the issues that managers notice, and the actions they take, are grounded in a background of shared cultural practices and skills, as well as the persons involved, the activities and settings. The focus on perceptions lends itself to a more qualitative research design. In this regard, this chapter describes the qualitative research design and the specific methods that were used to gather data from the managers, suffice to say that the study mainly used personal in-depth interviews as the main data collection instrument. By way of progress, this chapter will provide a recap of the objectives of the study before discussing the empirical field of study, and the qualitative research design that was used to explore the study’s central concerns.
5.2 Recap of the research objectives

This exploratory qualitative research seeks to address in detail the management implications resulting from the increased internationalization of the workforce in the Aged Care Sector. This research seeks views of managers in aged care facilities in Dunedin only. This small setting is more suited to this study’s goal of exploring in detail, the managers’ perceptions of the implications arising from increased participation of migrants as carers. Research elsewhere reveals that there are many management challenges associated with migrant care workers with significant implications for management and the quality of care delivered to the elderly. The focus on a small setting provides a better opportunity to reflect on similarities and dissimilarities of these findings when compared to a relatively small setting within New Zealand. In addressing this aim, this study first profiles the migrant care workers in the aged care sector. The study then seeks the perceptions of management on the challenges emanating from the increased employment of migrant care workers with special regards to the quality of care delivered to the elderly. Finally the study investigates the coping strategies employed by the different managers to deal with the challenges.

5.3 Empirical field

Before providing a detailed discussion on the methods that were used to explore the objectives of this study, it is important to describe the empirical field of this research. The relevant empirical field of this study is all the aged care facilities and the managers of aged care facilities in Dunedin. A manager for the purposes of this study was defined as the person at the top level of the particular facility and also those who managed different units within the organisation. Ordinarily, managers at elder care institution are the overall facility manager and the unit nurse manager. The unit nurse manager has management responsibilities over a nursing unit in the aged care facility and reports to the facility manager. The unit nurse manager has primary responsibilities for doing the roster, budgeting, timesheets and overseeing the day-to-day operations of the unit. The careworkers report directly to the unit nurse manager. At some places the owners were interviewed because they were also the managers of the place. In the same vein, ‘aged care facility’ in this study refers to an aged care institution. In this respect, a nursing home is an institution providing nursing care 24 hours a day, assist with activities of daily living and mobility, psychosocial and personal care, paramedical care such as physiotherapy and occupational therapy, as well as provide room and board (Ribbe et al., 1997).
With reference to Dunedin, there are over twenty-eight aged care facilities. Ownership of these facilities range from church organisations, Dunedin owned and nationally owned. The number of managers at a facility varied due to the fact that some facilities had a facility manager and a clinical manager. Others had unit nurse managers and the rest had only one manager. This also depended on the size of the facility and the style of management favoured at that facility.

Connected to this discussion is the issue of the different types of care levels that are classified under the elderly care institutions. The type of licence determines the type of service available. In this respect, there are four broad categories of elderly care organisations, based on the level or intensity of care provided. These are (i) independent living communities; (ii) assisted living facilities; (iii) nursing homes; and (iv) organisations with a mix of these services (Madas & North, 2000). For a detailed description of the different forms of aged care institutions which make the population of this study, see Chapter 1 Section 1.6.1. The term population refers to the aggregate or totality of all the objects, subjects or members that conform to a set specification (Polit & Hungler, 1999). Therefore all the managers and aged care facilities in Dunedin are considered as the population of this study, from which a small sample of 16 were chosen to directly participate in the study.

Table 5.1 captures the profile of aged care institutions that were part of this study.
Table 5.1: Profile of aged care facilities included in the study

<table>
<thead>
<tr>
<th>Pseudonym of Facility/unit</th>
<th>Business Ownership</th>
<th>Type of facility</th>
<th>No of Beds at the facility</th>
<th>Number of managers Interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toyota Corolla Aqua Camry</td>
<td>Church</td>
<td>Hospital care</td>
<td>128</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dementia care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Psychogeriatric</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospital care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Independent living – rental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nissan Sunny</td>
<td>Church</td>
<td>Rest Home</td>
<td>65</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospital care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Honda Rafaga</td>
<td>Business</td>
<td>Hospital care</td>
<td>93</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dementia care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rest Home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Isuzu</td>
<td>Family Owned</td>
<td>Rest Home</td>
<td>28</td>
<td>1</td>
</tr>
<tr>
<td>Fiat</td>
<td>Trust funded</td>
<td>Rest Home</td>
<td>44</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lexus Volvo</td>
<td>National private organisation</td>
<td>Rest Home</td>
<td>33</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Independent Apartment Assisted Living</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audi</td>
<td>National private organisation</td>
<td>Independent Apartment Assisted Living</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Hyundai Sonata</td>
<td>Family owned</td>
<td>Rest Home</td>
<td>29</td>
<td>2</td>
</tr>
<tr>
<td>Holden</td>
<td>Dementia</td>
<td>26</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
In Dunedin there are mainly three types of aged care facilities. These are the church owned, individual or Dunedin owned, and publicly listed national organisations. The sample of managers that were used for this study was derived from all these different types of elder care institutions as represented in Table 5.1.

5.4 Ontological and epistemological premises: Interpretivism

In order to gain a better understanding of the choice of the methodology and methods that were used in exploring the managers’ perceptions of the experiences of migrant care workers, it is important to understand this study’s ontological and epistemological premises. It is widely agreed that ontology is “the starting point of all research” (Creswell, 1998; Crotty, 1998; Grix, 2002, 177). In this respect, ontology is defined as the “claims and assumptions that are made about the nature of social reality, claims about what exists, what it looks like, what units make it up, and how these units interact with each other” (Blaikie, 1993, 6). Blaikie further states that “ontological assumptions are concerned with what we believe constitutes social reality” (2000, 8). This study subscribes to the idea that there is no single reality but multiple realities. These realities depend on and are shaped by both the researcher and the research subjects’ personal history, setting, biography, gender, social class, race, ethnicity, education and various other factors. Reality is therefore largely defined by the actors’ personal experiences. These are therefore the lens that this study proposes to use in exploring the experiences of managers with regards to the employment of migrant carers.

In this respect, this study’s ontology can be described as interpretivism. This is because the ontological interpretivist approach to knowledge takes the stance that reality is relative and multiple and that there can be more than one reality and more than a single structured way of accessing such realities (Lincoln & Guba, 1985). Further, it is argued that these multiple meanings present interpretation difficulties since they depend on various systems for meanings (Lincoln & Guba, 1985). The meanings or knowledge emerging from these diverse systems is further complicated by the existence of diverse ways of interpreting, perceiving, knowing and explaining (Carson, Gilmore, Perry, & Gronhaug, 2001). This line of argument suggests that it is futile to expect diverse managers’, discussions as well as the interpretations of their articulations, to produce uniform accounts. The managers use systems of interpretation that are different from the researcher because of various factors, the most significant being culture. This also suggests that none of the two groups’ perspectives of interpretations can be said to be wrong.
A significant aspect of interpretivism as an ontology is that it subscribes to the view that the knowledge generated is perceived through socially constructed and subjective interpretations (Carson et al., 2001; Hudson and Ozanne, 1988). Interpretivists therefore consider meaning from the perspective of, for example, diverse subjective experiences, which are time and context bound (Hudson and Ozanne, 1988).

From an interpretivist perspective, the implication is that a study dealing with the perceptions of managers would acknowledge the critical position of the interviewer in the process of unravelling and interpreting the ‘inside story’ of the managers regarding the employment of migrants as carers. The researcher cannot be separated from the issues under discussion as well as the interpretations that are put on paper. The researcher therefore interprets meanings in ways that are conditioned by the researcher’s worldviews. The interpretivist ontology also implies that the perceptions of managers regarding the implications of employing migrant carers, especially in the context of quality care delivery, are bound to be varied.

5.5 Qualitative research design

In light of this ontological perspective that acknowledges the existence of a multiplicity of realities, it was therefore important for this study to seek a method that could enable the exploration of individual meanings and perceptions of elderly care facility managers about the implications of the increased participation of migrants as carers. In this regard, the interpretivist ontological premises of this study lent itself to the adoption of a qualitative research design as it seemed more suited to support the process of unravelling the multiple perceptions of the managers regarding the employment of migrants in relation to quality care delivery. Qualitative research involves an interpretive, naturalistic approach to its subject matter and gives priority to what the data contribute to important research questions or existing information (Noyes et al., 2008). Qualitative research is characterised by the investigation of things or phenomena in their natural settings and attempts to make sense of these things as well as interpret them in terms of the meanings people attach to them (Denzin & Lincoln 2005, 205).
Various studies have documented generic advantages of a qualitative research design. For example, it is generally agreed that a qualitative research design brings flexibility to follow sudden ideas that come up during the research as well as giving opportunity to the researcher to explore processes effectively (Alvesson, 1996; Bryman et al., 1988; Conger 1998). In this regard, it can be argued that a qualitative research approach is sensitive to contextual factors.

The qualitative approach was therefore useful in so far as it gave the researcher opportunities to explore management’s views, perceptions and experiences with migrant care workers, as well as get insights into what they think about addressing the challenges emanating from the increasing internationalisation of the aged care workforce. The qualitative methodology was used because it is better placed to provide, from a management’s perspective, a better in-depth understanding of characteristics of the aged care, as well as affording an opportunity to gain a deeper understanding of the challenges presented by those characteristics in terms of impacting the ability to deliver care at the required quality levels. It is for this reason that the main data collection technique used was the personal in-depth interview.

### 5.6 Data collection approaches: In-depth personal interviews

Qualitative research incorporates diverse philosophies, research designs and data collection techniques such as, inter alia, in-depth qualitative interviews; focus groups, triads, dyads, participant and non-participant observation; document analyses, in-depth interviews (Patton, 2002; Pope & Mays, 2006). In this regard, it is argued that qualitative researchers use interviews because they (interviews) are one of the most common and powerful methods, which can be used to gain a better understanding of other people (Bryman, 2004; Bryman, 1988; Fontana and Frey, 2003). Interviews involve some kind of “conversation with a purpose” (Kahn and Cannell, 1957, 149; Dexter, 1970, 136; Burgess, 1984, 102). The style is largely conversational, flexible which allows the purpose of the inquiry to be achieved through active engagement by both interviewer and interviewee around relevant issues, topics and experiences (Mason, 2002).

The major advantage of interviews is that they do not occur unintentionally but are intentionally designed and arranged to follow procedures and rules (Denzin and Lincoln, 2005). Interviews are better placed to investigate “elements of the social by asking people to talk, and to gather or construct knowledge by listening to and interpreting what they say and to how they say it” (Mason, 2002, 225). It is one of the reasons why qualitative researchers
use this data collection tools. In this regard, interviews generally afforded this researcher the opportunity to explore the views of management by giving them open ended questions that ultimately worked as prompts allowing the research subjects to talk freely about important issues that may have not been asked directly by the researcher.

As regards the specific interview method, this study mainly employed the in-depth personal interview technique to gather the relevant data needed to answer the research questions. In-depth interviewing is a qualitative research data gathering method that involves conducting thorough individual interviews with one or a small number of interviewees to explore their views on a particular idea, programme, or situation (Boyce & Neale, 2006). In depth interviewing was also conducted over the telephone as the researcher sought clarification on issues that emerged during data analysis stages.

The use of in-depth interviews with open-ended questions gave the managers space to express their experiences and knowledge related to the management of migrant care workers in relation to quality of service provided. In-depth interviews were also instrumental in gathering information in the managers’ own words from which insights on their perceptions of how migrant care workers impacted on the quality of care could be interpreted. The researcher also employed the informal conversational approach in same cases because it helped the managers to relax and be able to respond without thinking a lot about what the interviewer thought of them. This approach was used because of its strength that “resides in the opportunities it offers for flexibility, spontaneity, and responsiveness to individual differences and situational challenges” (Patton, 2002, 343).

5.6.1 In-depth interviews and Interpretivism ontology

At this juncture it may be important to discuss how the use of the in-depth interviews, as well as the actual interviewing process, was influenced by the interpretivist ontological premises of this study. Because knowledge, as argued by Legard, Keegan & Ward (2003) is not just given but created and negotiated between the participants and the interviewer, the researcher made a very conscious attempt to interact with the interviewees in search of their experiences regarding the employment of migrant carers. The interviewer was conscious, as is argued by Holstein & Gubrium (1997) that she was an active player in the development of data and of meaning and not just a “pipeline” (Holstein & Gubrium, 1997) through which knowledge is transmitted (see Section 5.9 in which the researcher discusses issues of reflexivity).
To this end therefore Kvale’s (1996) ‘traveller metaphor’ sums up this study’s approach in conducting the in-depth interviews:

“... The traveller … asks questions that lead the subjects to tell their own stories of their lived world, and converses with them in the original Latin meaning of conversation as ‘wandering together with’ (Kvale, 1996, 4, original emphasis).

Through the interviews, the researcher journeyed with the participants and intermittently led the participants to new insights. The interviewer, in a very interactive fashion, combined structure with flexibility in exploring the subject of migrant carers’ role in the aged care sector. To this end, the interviewer used an interview guide to structure the “conversation with purpose” with the managers of aged care facilities. The questions that were asked encouraged the interviewees to talk freely and the researcher joined in the development of knowledge by using a range of probes to “achieve depth of answer in terms of penetration, exploration and explanation (Legard et al., 2003, 141). The questions posed gave the interviewee relative freedom to talk about things of importance from their perspective. However, the researcher always made sure that the discussion centred on the issues that were related to the objectives of the study.

5.6.2 Interview schedule

In-depth personal interviews lasting around an hour were conducted with managers between December 2012 and January 2013.

The interview schedule had a few questions oriented towards eliciting the views of the managers on how they managed the migrant workers and supporting them to maintain the quality of service.

The following topics were covered by the schedule:

1. **Personal information of the employer** e.g. background information about the employer e.g. how long he has been managing the organisation
2. **Work environment challenges**: management style, co-workers relationships
3. **Migrant workforce profiles**: migrants carers’ numbers, characteristics, terms and conditions, reasons for their employment, countries of origin and reasons for recruiting from those countries, advantages and disadvantages of using migrant workers, their importance to the employer and the impact of not being able to recruit migrants;
4. **HR practices**: recruitment and selection, including the recruitment process, qualifications and other qualities sought, use of employment/recruitment agencies; training;

5. **Impact on quality of care**: this was the mediating factor for all questions
   (See Appendix 1 for an extended version of the Interview Schedule).

In designing these questions, the study was inspired by diverse extant literature conducted elsewhere that indicated that migrant careworkers face a lot of challenges at work. For example research by Spencer et al., (2010) documented diverse challenges that are faced by migrants that might compromise their ability to provide quality care. It was also therefore interesting to investigate the New Zealand scenario using these findings as a basis of understanding the managers’ level of awareness of the challenges their cohort of migrants face and what they had in place to combat the negative impacts.

### 5.7 Interview procedure

An invitation letter detailing the research (see Appendix 2) was hand-delivered to the managers as a way of creating rapport and getting to meet the manager before the interview. A follow up phone call was made a few days later as stated on the letter. When the researcher delivered interview invitation letters, a few managers indicated that they did not have any migrant care workers at their facilities. Because some of the facilities are very large, the researcher was able to interview managers of units within one facility. For example, as shown in Table 5.1 at one large facility, the researcher was able to interview 4 unit nurse managers whilst at others, only two or one were interviewed. During data analysis, the interviewer also made some follow-up interviews as had been promised during the one-to-one personal interviews. These follow-up interviews were very critical in ensuring clarity to vague issues that emerged during the data analysis and interpretation stages.

Given the significant roles that the researcher played in the interviewing process, such as prompting the interviewees to reveal their perceptions of the impact, and quality care delivery resulting from the increased participation of migrants as carers, it is important to briefly reflect on what the researcher brings to this process.
5.8 Issues of reflexivity and the interviewing process

In presenting this slice of the researcher’s life, the intention is to emphasize that the researcher’s culture and background mediated the meaning making process, during the conducting and analyses of interviews. The researcher can therefore not be divorced from the research.

It is generally agreed that since qualitative research tends to have the researcher as the primary “instrument” of data collection and analysis, reflexivity is of paramount importance (Glesne, 1999; Merriam, 1998; Russell & Kelly, 2002; Stake, 1995). Reflexivity is also defined as a “deconstructive exercise for locating the intersections of author, other, text, and world, and for penetrating the representational exercise itself” (Macbeth, 2001, 35). This brief inclusion of the ‘self’ is in recognition of the reality that the researcher’s own experiences cannot escape influencing various stages of the research process such as “conceptualization of the issues to be researched, relationships with research participants, to interpretation of findings, to writing up results, to dissemination” (Gilgun, 2010, 1).

The researcher is a black Zimbabwean who came to New Zealand in 2007. The researcher arrived in New Zealand having already completed a Master’s Degree in Business Administration and a Bachelor of Science Honours Degree in Human Resource Management. Before coming to Zimbabwe to join the partner who was pursuing a higher degree qualification, the researcher worked as a Human Resource Specialist with one of the most prestigious public sector companies in Zimbabwe. The culture shock could not be avoided especially when it dawned on the researcher that the new environment did not value highly the researcher’s management qualifications. Having realized that job opportunities that ordinarily the researcher would have had greater chances of securing in the researcher’s home environment, did not consider favourably the researcher’s qualifications, the researcher embarked on a Postgraduate diploma studies in management with the University of Otago. Most job opportunities availed themselves in the aged care sector and it was then that the researcher discovered personally the increasing number of migrant workers in this sector.

The researcher also met some migrants with similar problems who were struggling to come to an acceptance that carework was likely to be the job they had to take to make a living. Care work is generally a low level job and it is not entirely unreasonable to suggest that the author, and other migrants in similar positions, had to deal with a lot of stress and pressure associated
with doing a job that they had never consideration an alternative until they set foot in New Zealand. In this regard, reflection was critical to the researcher in terms of reminding the researcher in the interviewing process to be acutely aware of factors that could influence the research process.

To mitigate interviewer influence, the researcher carefully considered the issues that were under study and was consistently on guard to make sure those personal negative and positive experiences as a careworker did not impact on the inquiry. It was for this reason that the researcher carried to the interviews, the Human Rights Report by McGregor (2012) to prompt for more reactions from interviews. The managers appeared at ease to respond to ‘sensitive’ questions once they got an understanding that the author was making a follow-up on some issues that had already been raised elsewhere, and that the interview was not at all personal in light of the fact that the issues under discussion concerned the author as well.

The personal experiences of the researcher with carework were however useful in helping the researcher to meaningfully engage the management during the interviews. Having had so many conversations with other migrants before about the nature of ‘our’ jobs, these personal and shared views and experiences were integral in helping the researcher to evaluate the manager’s level of awareness of some critical challenges unique to the migrant careworker community.

In conducting the interviews, the researcher remained an interviewer with the primary role of prompting discussion of important issues and also directing the conversation to the issues that were closely related to the objectives of the study. The researcher did not overtly get involved in a debate with the managers’ responses.

5.9 Data analysis: ‘the search for themes’.

Morse (1994) observed that the term ‘qualitative research’ embraces a wide range of philosophical positions, methodological strategies, and analytical procedures. Morse’s conceptualisation of the cognitive processes involved in qualitative research in many ways captures this researcher’s cognitive processes during interactions with qualitative data in the process of generating themes relevant to the study objectives. Morse (1994) believes that all qualitative analysis, regardless of the specific approach, involves:

- comprehending the phenomenon under study
synthesising a portrait of the phenomenon that accounts for relations and linkages within its aspects

theorising about how and why these relations appear as they do,

and recontextualising, or putting the new knowledge about phenomena and relations back into the context of how others have articulated the evolving knowledge they face

This framework provided by Morse (1994) to a large extent influenced the approach that was taken in analysing the data. The research objectives were used as the reference point and helped therefore to systematically eliminate material that did not help to address the objectives of the study.

5.9.1 Data analysis procedure

Following is a summary of the data analysis steps that were actually taken to emerge with the various themes as presented in the next chapters:

Step 1: Transcribing the interview.

Although transcribing is considered time consuming it served two important purposes in the analysis of data. Transcribing formatted the raw data into a usable form and it also allowed the researcher to listen to the data repeatedly as it was being transcribed. This made the whole process easier for the researcher since she became more familiar with the data and also common themes begun developing during this stage. The sensitive nature of the topic encouraged the researcher to ask the managers if they wanted the interview to be recorded or not. Some managers were not comfortable with the recording so the interviewer took notes during the interview.

After every interview the researcher wrote up interview notes in detail for the unrecorded ones and did transcription of the recorded ones to reduce stress and reduce time. Most of the interviews were recorded and transcribed soon after each site visit.

Step 2: Preliminary exploratory analysis.

At this stage the researcher explored the transcribed data in order to become familiar with the interview information. Colour coding was used for each manager making it easy to know who said what without using the actual names. At this stage the research read the script over and
over again to make sure everything was captured. At this early stage the researcher begun to see themes developing from the transcribed data.

**Step 3: Making connections to the research questions: constant comparative analysis**

This involved grouping the information under the research questions. This involved the analysis of the managers’ answers to the questions and building themes that could address the research objectives. The researcher consistently applied the method of constant comparative analysis of Glaser and Strauss (1967). (See also Strauss, 1987; Glaser, 1992). This involved taking one piece of data, one interview, one statement, one theme) and comparing it with all others that may have appeared similar or different, in order to develop conceptualisations of the possible relations between all the interviews. The researcher made rigours attempts to compare accounts and experiences of the different managers with the employment of migrant careworkers.

Pope, Ziebland, and Mays (2000) argue that the technique of constant comparison of recorded interviews or data has the advantage of being inclusive as well as allowing the researcher to add categories to reflect as many of the nuances in the data as possible, rather than reducing the data to a few numerical codes. Sections of the data will typically include multiple themes, so it is important to have some system of cross indexing to deal with this. From the comparison, the researcher was able to stand back and think about the implications of the managers’ experiences, for example in relation to quality of care, retention of migrants and their working conditions. This enabled the researcher to draw conclusions as to whether or not the managers had given thought in their management practices regarding the importance of understanding the special attributes of migrants and how these could be managed to avoid compromising quality care delivery.

**5.10 Chapter Summary**

This chapter has explained in detail the research methodology and methods that were adopted for the purpose of achieving the objectives of this study. It also provided a detailed justification of the qualitative research design and data collection instruments used in the study. The following chapter presents and analyses the findings of the study.
Chapter 6: Presentation and analysis of findings

6.1 Introduction

This chapter presents findings about the characteristics of migrant carers found in the aged care facilities that are part of this study and the profiles of both managers and the migrant careworkers. The chapter also presents findings about the perceptions of managers regarding the growth patterns of the aged care sector and rising demand for aged care services against a dwindling labour supply. It is therefore important to re-emphasise the point that these issues are presented from the perspective of managers of aged care facilities in Dunedin.

6.2 Profile of Aged Care Facilities and managers that took part in this study

The findings presented here were gathered from managers and unit nurse managers of aged care facilities that range in size from the very small, employing less than 20 employees, to medium-sized (20-50), and larger establishments employing 50 or more people.
Table 6.1 Profile of Managers of Aged Care Facilities

<table>
<thead>
<tr>
<th>Name of aged care facility (Pseudonym)</th>
<th>Position of person interviewed</th>
<th>Number of years on the position</th>
<th>Number of employees and carers</th>
<th>Migrant employee to non-migrant employee ratio</th>
<th>Nature of ownership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audi</td>
<td>Manager</td>
<td>15yrs</td>
<td>45 staff/23 carers</td>
<td>0</td>
<td>Public business</td>
</tr>
<tr>
<td>Isuzu</td>
<td>Manager/owner</td>
<td>7yrs</td>
<td>22 staff/16 carers</td>
<td>1:3</td>
<td>Private Business</td>
</tr>
<tr>
<td>Holden</td>
<td>Manager</td>
<td>9yrs</td>
<td>17 staff/13 carers</td>
<td>6:7</td>
<td>Private Business</td>
</tr>
<tr>
<td>Honda</td>
<td>Nurse manager</td>
<td>2y</td>
<td>81 staff/54 carers</td>
<td>4:23</td>
<td>Public Business</td>
</tr>
<tr>
<td>Lexus</td>
<td>Manager</td>
<td>1.3yr</td>
<td>24 staff/18 carers</td>
<td>5:13</td>
<td>Private Business</td>
</tr>
<tr>
<td>Nissan</td>
<td>Manager</td>
<td>5yrs</td>
<td>75 staff/65 carers</td>
<td>2:11</td>
<td>International Church Organisation</td>
</tr>
<tr>
<td>Hyundai</td>
<td>Manager/owner</td>
<td>39yrs</td>
<td>29 staff/23 carers</td>
<td>0</td>
<td>Private Business</td>
</tr>
<tr>
<td>Sonata</td>
<td>Nurse</td>
<td>6yrs</td>
<td>29 staff/23 carers</td>
<td>0</td>
<td>Private Business</td>
</tr>
<tr>
<td>Sunny</td>
<td>Nurse</td>
<td>5yrs</td>
<td>75 staff/65 carers</td>
<td>2:11</td>
<td>International church organisation</td>
</tr>
<tr>
<td>Toyota</td>
<td>Manager</td>
<td>13yrs</td>
<td>103 staff/88 carers</td>
<td>13:75</td>
<td>National big church organisation</td>
</tr>
<tr>
<td>Rafaga</td>
<td>Manager</td>
<td>23yrs</td>
<td>81 staff/54 carers</td>
<td>4:23</td>
<td>National big organisation</td>
</tr>
<tr>
<td>Camry</td>
<td>Nurse Manager</td>
<td>3yrs</td>
<td>22 permanent employed (hospital level)</td>
<td>3:8</td>
<td>National big church organisation</td>
</tr>
<tr>
<td>Fiat</td>
<td>Manager</td>
<td>19yrs</td>
<td>38 staff/28 carers</td>
<td>2:5</td>
<td>Charity Business</td>
</tr>
<tr>
<td>Corolla</td>
<td>Nurse Manager</td>
<td>20yrs</td>
<td>20 attached to the two rest homes</td>
<td>1:19</td>
<td>National church organisation</td>
</tr>
<tr>
<td>Aqua</td>
<td>Nurse manager</td>
<td>20yrs</td>
<td>15 full time Dementia unit</td>
<td>1:2</td>
<td>National church organisation</td>
</tr>
<tr>
<td>Volvo</td>
<td>Nurse Manager</td>
<td>1yr</td>
<td>20 full time</td>
<td>1:3</td>
<td>Private Business</td>
</tr>
</tbody>
</table>
Table 6.1 shows the number of managers that were interviewed and the type of facilities they are managing. For confidentiality purposes, pseudonyms have been used to identify the facilities as well as the names of managers that were interviewed, as seen in Table 6.2 below. Table 6.1 also indicates the numbers of years each of the interviewed managers has had managing the aged care facility or general experiences in the aged care sector.

This information is important in that ordinarily the number of years one has spent in an institution provides valuable experience and knowledge about trends in migrant care employment as well as a better understanding of the realities of employing migrant care workers. At each facility, the managers were asked to provide the number of migrant care workers in their employment. As can be seen, the total number of migrant care workers in each organization varied. The managers also revealed that the number of carers employed depended on a number of variables such as the number of residents or the expected levels of care to be offered.

The following Table 6.2 shows the pseudonyms of the managers that were interviewed in this study. Overall there were sixteen managers interview, of which only two males.

**Table 6.2 Pseudonyms for Managers and nurse managers of Aged Care Study Units**

<table>
<thead>
<tr>
<th>Managers</th>
<th>Nurse managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alex</td>
<td>Erin</td>
</tr>
<tr>
<td>Lindsay</td>
<td>Cameron</td>
</tr>
<tr>
<td>Bailey</td>
<td>Casey</td>
</tr>
<tr>
<td>Cecil</td>
<td>Cody</td>
</tr>
<tr>
<td>Drew</td>
<td>Dakota</td>
</tr>
<tr>
<td>Mason</td>
<td>Madison</td>
</tr>
<tr>
<td>Christian</td>
<td>Marley</td>
</tr>
<tr>
<td>Emerson</td>
<td></td>
</tr>
<tr>
<td>Lee</td>
<td></td>
</tr>
</tbody>
</table>

In order to protect the anonymity of the participants, the information shown above does not show the link between the facilities and the managers. Nine facility managers and seven nurse managers were therefore interviewed. In presenting the findings, reference will be made to the names of these managers without necessarily linking them to the facilities they manage.
6.3 Educational qualifications of the migrants

The statistics collected during the field research found that most of the migrants employed as carers had the minimum educational qualification of a high school certificate. The majority however had completed diploma, postgraduate diploma or Master’s Degree in their home countries as shown in Table 6.3. Some of the migrant carers were qualified nurses in their home countries awaiting accreditation to be allowed to practice as Registered Nurses in New Zealand.

Table 6.3 supports earlier literature discussions to the effect that most migrants are highly qualified but encounter problems securing jobs that they are trained for and therefore seek care jobs as a last resort. This subject of ‘underemployment’ of migrants is discussed in detail in Chapter 7 Section 7.3.
<table>
<thead>
<tr>
<th>Name of place/unit (Pseudonym)</th>
<th>Number of migrant workers</th>
<th>Highest qualifications held by migrant carers (overseas)</th>
<th>Lowest qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audi</td>
<td>0</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Isuzu</td>
<td>4</td>
<td>-Master’s degree -Degree</td>
<td>-High school certificate</td>
</tr>
<tr>
<td>Holden</td>
<td>6</td>
<td>- Degree -Diploma (nursing)</td>
<td>-High school certificate</td>
</tr>
<tr>
<td>Honda</td>
<td>8</td>
<td>- Post grad diploma -Degree</td>
<td>-High school certificate</td>
</tr>
<tr>
<td>Lexus</td>
<td>5</td>
<td>-Master’s degree; Degree -Post graduate diploma</td>
<td>-High school certificate</td>
</tr>
<tr>
<td>Nissan</td>
<td>10</td>
<td>-Master’s degree; Graduate diploma –Degree; -Diploma</td>
<td>-High school certificate</td>
</tr>
<tr>
<td>Hyundai</td>
<td>0</td>
<td>N/a</td>
<td>N/a</td>
</tr>
<tr>
<td>Sonata</td>
<td>0</td>
<td>N/a</td>
<td>N/a</td>
</tr>
<tr>
<td>Sunny</td>
<td>10</td>
<td>-Master’s degree; -Graduate diploma; -Degree; -Diploma</td>
<td>-High school certificate</td>
</tr>
<tr>
<td>Toyota</td>
<td>13</td>
<td>-Master’s degree, -Post graduate diploma; Postgraduate certificate -Graduate diploma; Degree</td>
<td>-High school certificate</td>
</tr>
<tr>
<td>Rafaga</td>
<td>8</td>
<td>- Post grad diploma -Degree</td>
<td>-High school certificate</td>
</tr>
<tr>
<td>Camry</td>
<td>6</td>
<td>-Master’s degree, -Postgraduate certificate; Graduate diploma</td>
<td>-High school certificate</td>
</tr>
<tr>
<td>Fiat</td>
<td>8</td>
<td>-Master’s degree -Degree, Diploma</td>
<td>-High school certificate</td>
</tr>
<tr>
<td>Corolla</td>
<td>1</td>
<td>-Degree</td>
<td>N/a</td>
</tr>
<tr>
<td>Aqua</td>
<td>5</td>
<td>-Master’s degree; -Post graduate diploma; Degree</td>
<td>-Diploma</td>
</tr>
<tr>
<td>Volvo</td>
<td>5</td>
<td>-Master’s degree; Post graduate diploma -Degree</td>
<td>-High school certificate</td>
</tr>
</tbody>
</table>
6.4 Profile of managers

Five managers said that they had had overseas nursing experience while eleven had only worked in New Zealand. There were two male managers and fourteen female managers. The time the interviewees had spent at the different facilities was also considered in this study. This was important because the study was interested in recording their experiences and perceptions of the changes in numbers of migrant careworker recruitment in the past years. Figure 6.1 shows the number of years the interviewees have spent at their facilities.

![Years Spent At The Facility]

**Figure 6.1 Managers’ tenure at the Care facility**

This figure reflects the number of years each interviewed manager has spent at each facility as a manager. Bigger facilities have a facility manager and several Unit Managers. Perhaps this is due to the high turnover of nurses leaving for Australia and other countries. Figure 6.1 also shows that there were no nurses who had spent over 21 years at any of the facilities included in this study. In this regard one participant, Christian said that it was sad to see most nurses leaving for Australia. This was echoed by Bailey who said that they had recently lost 5 nurses to Australia either to join their husbands/partners working in the mines or taking up nursing job offers. Those managers who had been at any of the facilities for a relatively long period were, in most cases, owners of the facilities.
In response to the interviewer’s request that they share their views about the aged care sector and the policy interventions, all the managers were in agreement that the aged care sector deserved more attention from policy makers. For example, Lindsay said that, “We need to be aware of the critical role that this sector plays...we are in charge of the welfare of the old in our midst”. This view was echoed by Dakota who said that “we take care of the old... some of these people have done a lot for society in general... they deserve better...”

All the managers were in unison that the aged care sector was registering incredible growth and this had put unprecedented pressure on the health care system. The managers said that they had seen a phenomenal increase in the number of people needing elderly care. At Camry Facility, the manager said that there was need for more carers. The managers also said that they had noticed that their carers were getting old and could not cope with the physical demands of caregiving. Drew said that she had also noticed that a number of people were living beyond a hundred years. She said that such people were very difficult to care for because at that age, they are usually unable to do anything for themselves. This was made worse by the fact that those providing care to them were also ageing and therefore physically unable to cope with the demands of people in almost a ‘vegetative’ state. Christian said that at her facility, they had “3 residents who are over 100 years old. One is 101 years old and the other two are 100 years old. Carers have been here for a while although they are also ageing...”

The managers also echoed the view that they have over the years found it increasingly difficult to adequately staff their facilities as a result of reasons such as high staff turnover. In response to the question about what they were doing to address this problem, an overwhelming majority of the managers said that they had turned to the people who migrate to New Zealand from other countries. Manager Cameron said that, “…we have benefitted from the increased number of migrants coming to New Zealand...most for them do not quickly find their preferred jobs when they arrive in the country... we receive a lot of job applications from such people...”

These views were further expressed by Drew who said that, “I have to be honest... our facilities are increasingly relying on people migrating to New Zealand from other
countries… these foreigners are playing a very significant role in our facilities…’. To this end, the majority of the interviewees acknowledged the ‘significant role’ of migrants in helping their facilities to deliver care adequately to their patients.

The views of these managers resonate with Kluzer, Redecker, and Centeno’s (2010, 1) observations that “One of the key challenges in Long-Term Care (LTC) is the increasing tension between a growing demand for care, and a decreasing number of available carers, together with a preference for domiciliary over residential care”.

In the same vein the managers acknowledged the view that migrants had become central to the provision of care in elderly care institutions, as over the year they had seen an increase in the number of migrants workers at their facilities. All the interviewees agreed that migrant care workers had become the backbone of long-term institutionalised care services. To this end, Drew said that, “When we look at this industry... seriously it’s hard to attract young local people ... the only way you can run these facilities properly is by hiring foreigners... the truth is whether we like it or not, the need to employ foreigners will continue to rise....

This study supports studies conducted overseas (Cangiano et al., 2009; Spencer et al., 2010) which shows that the migrant share of the social care workforce continues to rise.

6.6 Change in numbers of migrant care workers over time

Data collected during field research indicate that the number of migrant workers employed in the elder-care facility sector in Dunedin has grown significantly since 2006-2007. All the managers indicated that before the year 2006, they had had very few migrant workers in their employment. The managers however did not have hard data to show the percentage increase of migrant employment since 2006, suffice to say that they all said that they had observed an increase in the employment of migrant carers. However, the managers had statistics regarding the nationality of the migrants working for them.

Regarding trends in the employment of migrants, the majority of the managers said that when they first started employing migrant workers about year 2005-6, they had been deliberately recruiting workers from the Pacific region countries because they were the most convenient source of migrant workers available. This was also aided by the fact that New Zealand’s Immigration Policy encouraged the recruitment of people from the Pacific region countries such as Cook Islands, Tonga, Rarotonga, Tuvalu and Samoa among others. However over
time, those employed as carers have come from all over the world. In this respect, Emerson said that, “I can say maybe in the past 6-7 years we have seen more coming from other countries... previously, it used to be from the Pacific...”

Table 6.4 shows the country origins of the migrant care workers at the facilities that were part of this study.

Table 6.4 Nationalities of migrant carers

<table>
<thead>
<tr>
<th>Asia</th>
<th>Africa</th>
<th>Asia-Pacific</th>
<th>Europe</th>
<th>USA</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>South</td>
<td>Samoa</td>
<td>Scotland</td>
<td>Canada</td>
</tr>
<tr>
<td>16</td>
<td>Africa</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Philippines</td>
<td>Zambia</td>
<td>Fiji</td>
<td>England</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>China</td>
<td>Zimbabwe</td>
<td>Tonga</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pakistan</td>
<td>Malawi</td>
<td>Rarotonga</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nepal</td>
<td>Tanzania</td>
<td>Tuvalu</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palestine</td>
<td>Ghana</td>
<td>Australia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indonesia</td>
<td>Kenya</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taiwan</td>
<td>Nigeria</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thailand</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total 32</td>
<td>Total 11</td>
<td>Total 9</td>
<td>Total 2</td>
<td>Total 1</td>
</tr>
</tbody>
</table>

As shown in Table 6.4 the migrant workers who are employed in the facilities that are part of this study share varied nationalities. The largest group of the migrant workers is made up of Indians and Filipinos. Table 6.4 also shows the geographical regions these migrant care
workers are coming from. Most migrants employed as care workers are from developing countries. Asia has the most migrant careworkers followed by Africa.

6.7 Age and gender of migrant care workers

Of the migrant carers employed by the managers who took part in this study, the majority were students aged around 18 to 35 ranging from first year of University to post graduates of different qualifications, student nurses to qualified nurses from overseas (doing their English tests or Competence Assessment Programme (CAP) for Nurses) or other carers in their thirties. It was clear from the study that the migrant workforce in Dunedin is an overwhelmingly young workforce. The CAP nursing programme gives both New Zealand Registered Nurses, Enrolled Nurses returning to practice after five years or more, and internationally qualified Registered Nurses, the opportunity to obtain their current practicing certificate through this competency assessment programme. Most qualified nurses from overseas countries tend to work as careworkers as they wait accreditation. The managers also noted that because some of the overseas nurses are not very competent in English because they have a non-English speaking background. They find the International English Language Testing System (IELTS) requirement of 7.0 Academic (no lower than 7.0 in reading, listening, writing and speaking subtests) very challenging and therefore may spend a longer time than English speaking nurses to be accredited. These views of the managers are also echoed in a 2010 study commissioned by the Labour and Green Parties and Grey Power which found that,

“Many nurses find the International English Language Testing System (IELTS) level 7 test difficult to pass, even after repeated attempts, so they end up working in the aged care sector, earning far less than they expected, and unable to keep up their clinical hours (necessary to maintain a valid nursing certificate). Many who have paid thousands of dollars to colleges and recruitment agencies in the hope of getting well paid jobs in public hospitals, find themselves trapped in low-paid care work” (2010, 37).

From the above findings three groups are clearly identifiable about migrant care workers in Dunedin. The first group is made up of registered nurses from mainly India and the Philippians. The second group is made up of qualified people with a wide range of other qualifications such as teaching, accounting, management, marketing, social work, lawyer to
name a few. The final group is made up of migrants who do not have any recognisable qualifications except a high school certificate.

A significant element of the profile of the migrant careworkers in Dunedin is the participation of students as carers. The managers indicated their profile of migrant workers had increased as more students found their way into the University of Otago, and Otago Polytechnic.

This view was expressed by Lindsay, who said that “... I think the reason is the University which attracts a lot of people from other countries... once they are here they look for jobs to pay for their bills...”

These same views were generally shared by most of the managers who, to quote nurse Manager Casey, “We provide the students with a flexible job that allows them to make extra money... most of them work during weekends... despite the nature of the job... I must make it clear that I don’t think this is an easy job to do... but it has its own advantages, I think, especially to the students from other counties....”

In this respect manager Cameron described carework as “popular with most students from other countries... I have yet to employ a local New Zealand student as a caregiver...”.

Manager Dakota said that she had employed some migrants “who really are not qualified in anything in particular... and some who were highly educated ... sometimes I have been puzzled as to why they take this job... I mean the qualified ones...”

In this respect, Bailey, Madison, and Cecil, said that they had discovered in their conversations with some of the migrant employees that some of them had come to New Zealand to escape ‘poverty’ or ‘wars’ in their home countries. Drew described some of the migrants who came to New Zealand as ‘economic refugees’. However, Lee and Erin said that they had also employed a number of people who originated from peaceful countries that were preforming economically better than New Zealand. An important point here is that not all the migrants share hostile background characteristics. These characterisations of migrants therefore echo extant studies’ observations that migration is a result of push and pull factors (Baum, 2012).

Another important aspect of the profile of migrant workers is the gender dimension. The statistics reinforce existing findings regarding the increased internationalisation of the aged care sector (Iecovich 2000; Spencer, et al., 2010). The profiles of migrants reinforce findings
elsewhere that care provision for the elderly is largely performed by women, perhaps as has largely always been the case historically all over the world. It has been reported that women comprise nearly half of the 214-million international migrants around the world (Spencer, 2010; Spencer et al., 2010). Women generally constitute the bigger majority of carers in the Western industrialised countries (Kluzer et al., 2010) due to what has been termed the feminisation of international migration (Boyd & Grieco, 2003; Paiewonsky, 2007; Ramirez, Dominguez & Morais, 2005). The findings in this study also confirm this observation because an overwhelming majority of the migrant carers at the facilities, that made part of this study, were female.

6.8 Profile of migrant workers: some emerging observations

A significant point emerging from the views of management, in relation to the profile of their cohort of migrant workers, is that most managers have information about the national origins of their migrant workers. Some of the managers had taken time to inquire about the reasons why the migrants were in New Zealand as evidenced by their responses to the effect that they had noticed a growing number of foreign students applying for jobs with their facilities. Some of the managers were aware that some of their migrant applicants had qualifications in other fields but found it difficult to secure their ‘preferred jobs’ which they were trained for. Some of the managers had taken time to inquire about the reasons the foreigners had emigrated to New Zealand, also discovered the challenging environments that had pushed some of the migrant carers out of their home countries such as the desire to escape violence and poverty.

These are significant findings as they echo past studies that have found that most migrants share a difficult history. Castle (2001) for example, in the attempt to categorise migrants, emerges with various subgroups that underline the fact that most migrants are pushed away from their home environments. For women, it may be a question of moving from one oppressive environment to another.

The literature reviewed about migrants suggests that most of them are already a group of people facing traumatic experiences in their private lives. In addition, the literature suggests that there is generally a mismatch between the qualifications of the migrant and the carework job (Anderson & Winefield, 2011; McKee-Ryan & Harvey, 2011). Observations by some of the managers, that most of the migrants were highly educated and skilled in other economic
fields, also echo past studies’ findings to the effect that many migrants experience underemployment when they land in a foreign country. Underemployment is an umbrella term used to refer to a wide range of unsatisfactory worker experiences related to being underrated or not having the chance to maximise one’s working goals (Feldman, 1996). (‘Underemployment’ will be discussed in detail in Chapter 7 Section 7.3)

Perhaps a more interesting point emerges in respect of the responses of management regarding their perceptions about the implications of the employment of these migrants as carers, to the quality of care provided. The overwhelming majority of the managers echoed each other in saying that the migrants had not compromised the facilities’ ability to deliver quality care to the elderly. However, the managers seemed to contradict themselves in this matter when responding to the poor communication skills of most migrants, vis-à-vis delivery of quality care to the elderly. This issue is discussed in detail in Chapter 7.

6.9 To employ or not to employ migrants: the rationale for migrant employment

A feature of the managers’ discussion of the issues significant to the aged care sector and quality care delivery was the manner in which an overwhelming majority of them acknowledged the positive role of the migrants. Only two of the managers interviewed said were no particular advantages in recruiting migrant care workers, other than that they ‘are available’. The majority of the managers shared the perception that the advantages of employing the migrants outweighed by far the negatives. For example when asked to explain why they were increasingly employing migrants, manager Casey, expressing the generally shared opinion about migrant workers, said that:

“Well, when I advertise it’s not like I will be looking for migrant carers but most of the times when you look at the applicants you find migrants have better CV’s and they have better referees than the locals. Even the police checks are always clean with migrants because they always try to be on the right side of the law. I have worked with them and they are very willing to work, eager to learn and very reliable. When I am doing the roster I know with migrants there won’t be any changes. Even when they are not feeling well, they still want to work... I have had to send some back home after realising they were not fit enough... the situation is different with some of our locals... when they ring sick especially on weekends, holidays and cold days... you can never tell whether they are genuine or not...”
The majority of the managers expressed the view that they were not able to attract as many local workers to their facilities and this had necessitated that they find alternative sources of workers. Invariably, this source turned out to be migrants. The managers perceived that the majority of the younger local people were not prepared to do carework especially considering the pay and general conditions on offer. The conditions of work, as well as the nature of carework, were perceived by managers to be responsible for the negative attitudes of native New Zealanders towards the job.

The difficulties assisted with the hiring of native workers to take up positions as careworkers was were underlined by one manager who said that:

“Some of these young people are pushed into getting a job and when they go to WINZ [Work and Income New Zealand] they find caregiving at the bottom of the list... so obviously they don’t see it as something that is valuable to the community. I advertise with WINZ...to tell you the truth the Kiwis who are registered there will apply for the job but they rarely make themselves available for interviews.... if they do decide to come for interviews, they usually come looking not so professional...they put on things that just put you off ... you can tell they don’t want the job...”

In this context, manager Bailey recounted an experience with a Kiwi local worker who when called to work, stated that she did not do showers, nor did she want to clean the patients or administer medication. This is despite the fact that these are integral components of elderly care provision. Another manager said that the young female school leavers that they had employed as carers found it very uncomfortable to shower a male resident. Dealing with death was also mentioned as one of the reasons that the younger native people did not want to do care jobs.

The unavailability of ‘good shifts’ also emerged as a hindrance to attracting native workers. The managers defined ‘good shifts’ as the shifts that take place during day time. These shifts are attractive because they allow one to be with family and friends in the evening as well as attend social private functions which ordinarily take place in the evenings. The 7am to 3pm shift was therefore mostly seen as the ‘good shift’ and not surprisingly, the most preferred and oversubscribed. In the event that a vacancy opened up, the other careworkers who would have been at that institution for some time would quickly ask to be moved to that 7am to 3pm shift.
The other manager said that although most, if not all locals, were not keen to take up elder care as a job, the situation was dire with the “young generation”. The younger generation was described as totally removed from the idea of carework as a career. In this respect, manager Lee said the local natives that applied for positions at elder care institutions tended to want to work “in the kitchen or do some other lighter duties”. The other manager said that the young people’s work ethic was not in harmony with the difficult tasks of cleaning, bathing and feeding the elderly. In the same vein, the manager of Isuzu, Lindsay, perceived that the refusal by local New Zealanders to take up care jobs had not significantly affected the quality of care. This was corroborated by manager Casey, who said that the ‘replacements’, referring to migrant careworkers, had in fact proved capable of sustaining high levels of quality care delivery.

The shortage of locals, poor salary and working conditions, the nature of carework, as well as the attitudes of the locals towards carework and migrant workers’ positive work ethic, emerged as the main reasons for employing migrant workers. These views of the managers resonate with findings of a study that was done in Ireland as indicated in Figure 6.3.

![Figure 6.2: Reasons why managers employ more migrant carers than native carers](image)

Walsh and O’Shea (2009, 53)
6.9.1 Positive attributes of migrant employees

The managers also largely agreed that the negatives or challenges associated with employing migrant carers were easily offset by the many positive attributes that migrants brought to the workplace. Most of the managers cited a range of positive attributes they associated with migrant workers. Their responses echoed each other when they talked about reliability, willingness to work hard, and the general attitude to work of migrant careworkers. Migrant carers were said to be more ‘reliable’ than most of the domestic carers who could not be depended on to turn up for work. For example, the young local New Zealanders could not be relied upon to turn up for work every time they were required to. Most managers agreed that migrant care workers worked all the days they are rostered for work and they never ‘surprise you... they pitch up for work when they are needed… when they put their names on the roster for extra shifts, they always turn up…” The majority of the managers described migrant careworkers invariably as ‘very hardworking’ ‘flexible and usually come to work even when given a very short notice to cover up for some unexpected gaps…”

Most of the managers expressed pride in their migrant cohort of employees for showing little preference for certain type of shifts. The managers perceived that migrant carers did not mind the time they were slotted in to come for work and therefore did the morning, day and night shifts without complaining. The managers also agreed that most of the migrant carers differentiated themselves from the native cohort of employees through ‘excellent dedication’ and ‘commitment to whatever task they are given’.

In some cases migrants showed their dedication and commitment to the caring of the adults by accepting to work double shifts in the event that one of the workers failed to report for duty. One manager said that migrant carers finished all the necessary tasks in time and took time to help those lagging behind. Some of the managers said that most of the migrants were prepared to work long hours, during public holidays, as well as working unsociable hours beyond the normal working day.

One manager for example said that migrant workers did not mind doing overtime and said that “in fact they actively seek it to earn extra money”. However, some of the managers said that they did not believe that when migrant’s workers ask to work double shifts, they were purely motivated by monetary gains. They said that some of the migrants genuinely cared for the patients and had developed a relationship with their patients.
The majority of the managers shared the view that migrant workers had an ‘admirable’ and ‘good’ attitude towards their work. They all talked highly about the work ethic of the migrant care worker and added that migrants came across as highly motivated and self-directed people requiring minimal supervision during the discharge of their carer duties.

Some studies however, have proffered interesting explanations about these positive qualities of migrant carers that the interviewed managers raised. For example, Näre (2013) makes some very interesting comments about these qualities that most employees highlight regarding the employability or flexibility of migrant carers by arguing that “Having to yield to increasing flexibility demands is a manifestation of the migrants’ structurally unequal position in the labour market” (2013, 76). Näre’s research in Finland further makes some very incisive comments about how employers take advantage of migrants’ weaker position, which forces them to be flexible and do odd shifts at work. Näre observes, in the Finnish context, that:

“…the migrant workers’ weaker position and the discrimination they encounter in the Finnish labour markets leads to qualities which from the employers’ perspective are very attractive: being flexible at any cost…migrant workers are kinder and easier for the employer, that is, malleable and compliant labour” (2013, 76).

In the same vein, Walsh & O’shea (2009, 110-111) reinforce this argument when they argue that “what may be perceived as a willingness to work could be a product of feelings of obligation, pressure, lack of choice, or an individual thinking that they simply cannot say ‘No’”. In the same vein it is argued that the power advantages that an employer has over the migrant carers can lead to this characterisation of migrants as very hardworking and flexible (Phillipson, 2007).

6.10 Conclusion

The chapter has presented findings about the diversity of the migrant carers in terms of their country of origin. The findings show that the aged care sector employment profile is increasingly becoming populated by migrant carers. It is also interesting to note that the managers are aware of, and acknowledge as well, the important role the migrants are playing in the delivery of care in aged care institutions. Also important is that some of the managers have taken time to get closer to their migrants and in the process have discovered some important details about their background characteristics. Some sections of the following
chapters will also look at whether or not the managers consider these social, economic and professional background of migrants significant in the quality of care delivered to the elderly patients. The chapter also recorded the perceptions of the managers to the effect that the employment of migrants as carers had largely enhanced quality care delivery. This is not to say that there are no challenges with the employment of these migrants as carers. To this end, Chapter 7 presents the views of the managers regarding the challenges that accompany the employment of migrant worker
Chapter 7: Migrant careworkers’ workplaces challenges: ‘a view from the top’

7.1 Introduction

Notwithstanding the positives that the migrants have brought to the aged care sector, as discussed in the previous chapter, there are various challenges that accompany the employment of migrants that potentially can disrupt quality care delivery. To this end, this chapter presents the views of the managers regarding the employment of migrant carers. The challenges discussed here include administrative ones such as the recruitment, selection, training and induction of migrants into the new care service culture. Most of the managers described the VISA requirements, as well as poor English proficiency skills of most migrants, as a big hindrance to the delivery of quality elder care. The chapter also presents evidence that show that managers are aware migrants encounter challenges such as perceived racism and discrimination that have implications for quality care delivery. The managers have also put in place some coping strategies to ameliorate these challenges although the potency of these responses is questionable.

7.2 Migrant careworker employment: some recruitment and administrative challenges

The literature on recruitment, selection and retention of employees suggest that better wages, training and provision of opportunities for career advancement, innovative job task management, as well as an intense focus on safety standards can improve recruitment and retention (Badkar et al., 2009; Booth, Miller & Mor, 2007). The concept of competitive advantage that underpins this study’s HRM theoretical framework is described by Porter (1980) as the essence of competitive strategy. Porter suggests that there are three competitive strategies that organizations can use to gain competitive advantage: innovation, quality enhancement, and cost reduction. Of interest here is the innovation strategy, precisely because it reinforces the soft HRM approach taken in this study as more suited to ensuring that the human resources perform at optimal levels, delivering compassionate, loving, kind and patient care to the elderly. The innovation strategy is especially attractive because the focus is on developing products or services different from those of competitors, and in turn suggests the imperative of crafting innovative strategies to deal with migrant carers to help deliver quality care. When considering the recruitment, retention, training and personal development of migrant carers, the emphasis is on how all the activities can contribute to the delivery of high quality care, which will in turn invite good publicity that is necessary if the aged care centre is
to continue to attract more business, in this case, more aged care patients. The selection of the right people for the job is therefore imperative in helping organisations to remain competitive.

In this regard, one of the challenges that has emerged due to the sector’s reliance on migrants as careworkers, starts from the managers’ point of initial engagement with the migrants: the recruitment and selection of the migrant carers. The HR policies and procedures associated with the recruitment, selection, training and compensation of migrant carers are all issues of importance that the managers raised in the interviews. In this respect, one of the challenges they faced in employing migrant as carers had to do with compliances with New Zealand Government’s Immigration Policy with regards to work permit processing and the paperwork associated with the recruitment of migrants. The whole process of advertising and explaining to the Immigration Department why they were contemplating employing a migrant as a carerworker, instead of a local applicant, was fraught with many hurdles.

Most of the managers complained that the process of getting a work permit for the migrant carer applicant was time consuming and expensive. In this respect, Dakota complained that the paperwork associated with the processing of a VISA added another layer to their workloads. Manager Lee said that ‘The main challenge is the visa issues. I have to advertise and explain why I have given that job to a migrant worker’. In the same vein, Lee said that it was not always easy to get Immigration NZ to grant foreign applicants work permit especially for carework. This is because the authorities view carework as a low skill requirement job. Most managers interviewed therefore said that they were bound by the laws of the country in their recruitment practices which made the recruitment of migrants such “a nightmare for most of us”, to quote Cody.

The New Zealand Government Immigration Policy states that employers that need to employ a migrant worker, must “establish that they are eligible and there are no New Zealanders available to do” (NZ Government, 2013, 4).

Manager Emerson said that this situation was compounded by trends that indicated “… that most of the unemployed locals do not really consider caregiving as a viable option…..” Manager Emerson also said that she always advertised her current vacancies with WINZ [Work Income New Zealand] “…but to tell you the truth, most of the Kiwis who are registered there will apply for the job but in most cases they don’t come for interviews … if
they do turn up, they come wearing things that will just put you off ... you can tell they don’t want the job…”

In the same context, manager Bailey suspected that this behaviour pattern had also been partly triggered by the government’s requirement that those receiving some financial benefit from the government had to show evidence of looking for a job in order to continue receiving the benefit. In her view, some of those applying to be considered as caregivers, but turn up looking very unprofessional, were simply doing this to provide evidence that they were actively looking for employment, but not necessarily prepared to be employed as carers: “I think this explains why some of them turn up for interviews looking unprofessional... Some of them simply want to show up to provide evidence to whoever needs it that they are making efforts to secure employment”.

The managers said that they could not however support the migrant visa application on the basis of the locals’ generally negative attitudes to carework as that was likely to court a lot of controversy. Manager Lee however said that she empathised with the government’s position of not granting visas to foreigners on account of coming into the country to do carework because “there is a high rate of unemployment in New Zealand and there are a lot of local people available to do this job... This job does not require special skills...if you know what I mean...”. She however added that, “The problem is that some of these local people are however not at all interested in taking caregiving as a career”.

All the managers therefore viewed the laws governing the employment of migrants as a hindrance to the employment of migrant carers.

**7.2.1 Recruitment and Training and administrative costs**

Another related challenge that was identified by most managers regarding the employment of migrants, had to do with the associated recruitment and training costs. The managers registered concern that in the few cases where the Immigration Department was prepared to grant or renew a migrant carer’s visa, “it seems to take ages to get the visa processed”, said manager Casey. This concern was echoed by Lee, who believed that the visa processing delays are more pronounced at the Dunedin Immigration Office “compared to Christchurch and Wellington. It only takes 2-3 days to process the visa up there... here it takes up to six weeks”.

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In this respect, Lindsay agreed that it was relatively easier for a migrant applicant to get a work visa renewed in Christchurch or Wellington than in Dunedin. To this end, Cecil, gave a specific example in which “a hardworking Pilipino girl was lost to Christchurch because of delays in renewing her visa at the Dunedin immigration offices... It took her no time to get her visa processed in Christchurch... I understand that she is now working for an agency...”

In the same vein, manager Casey recalled a time in the recent past when her facility lost four migrant carers because their visa renewal applications had been turned down by NZ Immigration. As a manager the concern was that the facility had invested a lot of money and time in training them to become excellent workers. The managers perceived that changes in immigration policy stipulations vis-à-vis work permit requirements for migrants applying for low skilled jobs were becoming too strict. To this end, Erin, said that there was a need to realise that the migrants “are doing a job that most of our people here are not prepared to do...” In agreement, Cody said that ‘the visa renewal applications for migrant carers needs to be given special attention especially when we consider this labour problem the whole industry is dealing with”. However, a few of the managers said that the visa processing delays were not unique to the Dunedin office. They believed it is a country-wide problem.

Another cost related with the hiring of migrants came in the form of training costs. Lindsay said that, “In the event that Immigration New Zealand declines to renew the visa, this is a big loss because all the training invested goes to waste”. In agreement, nurse manager Madison said that “…assuming that you have successfully secured a visa for the worker, there is still another problem.... The cost of training them so that they are able to support what we do here is huge…”

This view was supported by manager Cody who said that, “These days it’s getting worse because after all the paper work, they may only be given 3months to 1 year work permit... if you are lucky”. This meant that after three months the facility would need to advertise because the migrant worker’s visa would have expired. ‘It’s a nightmare to get the visas renewed. But since these carers are part of the team you go that extra mile in helping them to get their visa”. In this regard, most managers agreed that the impact to quality care delivery was largely negative. In this regard Cody said that “It affects quality in the sense that if they leave, you have to train someone else and it may take time for them to become part of the team”.

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In a related subject, one of the managers that recruited mostly from India was annoyed by the practice of ‘poaching’ which many managers of aged care facilities practiced. In this respect, Drew, whose facility recruits mostly from India, complained that ‘after bringing the employee and training them, some healthcare facilities in Dunedin are ‘poaching’ our careworkers. These managers lure most of our migrant employees by promising them guaranteed jobs after completing their CAP programme ...’ Drew said that this was especially “annoying after going through all the hassles of getting these people from India and also training them”.

From a competitive advantage strategic perspective, the managers’ concern about costs incurred in training migrants reflect most of the aged care facilities as being guided by Porter’s (1980) cost-reduction strategy that is characterised by tight controls, overhead minimization, and pursuit of economies of scale.

The managers also said that the problems did not stop even after successfully helping secure a visa for a migrant. In this respect Drew said that: “One of the biggest disadvantage is the fact that you have to keep track of the visa to make sure that it does not expire...We had a bad experience in the past when the visa was not checked and the person kept on working illegally without a valid visa... this became a serious matter for our facility”.

The managers therefore complained about the added workload related to the task of monitoring the migrant’ permits in order to avoid being penalised for employing a migrant with an expired visa.

The views of the managers about the role of immigration policies in relation to the employment of migrant workers to perform low skilled jobs such as caring for the elderly, are also echoed in studies done in the UK (see Cangiano and Shutes, 2010; Cangiano et al., 2009; Walsh and O’Shea, 2009; 2010). These latter studies suggest that current immigration regulations in a country are also a barrier for employers recruiting migrant workers (please see Section 7.2.3 below for a discussion of the implications to quality delivery emanating from visa issues).

7.2.2 Use of external recruitment agencies

In light of some of the challenges associated with migrants’ employment, managers Marley and Mason said that they had taken the position of not employing migrants who needed any sort of help with the processing of immigration paper work. The other managers however had
enlisted the help of recruitment agencies to help them with the recruitment of migrant carers. However, the managers said that they had later realised that this strategy has challenges of its own. For example, manager Cecil who had used an agency to recruit migrant carers a few years ago had found that “this method is very expensive for the organisation...” As a result, Cecil said that their facility had stopped using agents and resorted to filling up vacancies from the available pool of migrant applicants in Dunedin.

It is important here to mention the decision to cease using external recruitment agencies had been caused by observations of the costs being incurred by the organisation, and not cost incurred by the migrant applicants. Therefore a significant issue emanating from these managers’ responses is that they seem unaware of how migrants, who face visas and work permits, deal with this problem. All the managers that used recruitment agencies shared Lee’s view that: “I don’t know if the agencies exploit these people... they seem professional... The problem is that such information seems too personal... you can’t get the people to share such issues with you... I am not saying that I have tried to inquire about this...because, the truth is it has never crossed my mind.”

These views are interesting especially when considered from the viewpoint of findings elsewhere about the practices of some of the recruitment agencies. For example, a study conducted by Agunias (2013) established that migrants who face visa and work permit challenges, tend to resort to the use of private agencies that offer to assist financially with the processing of documentation and even ‘smuggling’ them to and from the country of choice. Agunias (2013) observed that such migrants tend to expose themselves to the various forms of abusive and exploitative practices of some of these unscrupulous agencies, who ‘overcharge’ them, forcing them to take loans that escalate, resulting in migrants failing to pay off the debts and therefore tying them to the exploitative agencies.

The revelation by Lee, earlier, to the effect that she had not seen any reason to inquire about the recruitment practices of the agencies she was using to hire migrants, is also interesting when considered from the viewpoint of a soft HRM perspective in which the sustainable competitive advantage of a firm is largely dependent on the effective utilisation and not exploitation of workers. This implies that the managers that are concerned about getting the best performance out of their employees should be as much concerned about the social and private lives of their employees as they are about their professional lives, without necessarily invading the privacy of the worker.
7.2.2.1 Reference checks challenges

The use of recruitment agencies was also seen as a solution to the problem of obtaining credible reference checks for migrant applicants. The managers had observed that this problem was more pronounced with new immigrants who had no local references within New Zealand. For those that had made attempts to recruit directly from overseas, they said that they had to deal with countless administrative challenges as well.

Most managers indicated that the employment of migrants was accompanied with numerous challenges such as reference checks. Most of the managers who employed migrants said that they faced numerous challenges in their attempts to obtain references for applicants from overseas. In this regard, manager Drew said that, “the process of recruiting from abroad is also made worse by the fact that it is not easy to obtain their references”. Manager Cecil said that “because we deal with people’s lives, we want to be sure that the people we employ are the right ones for the job”. Her concerns were echoed by manager Emerson who said that, “References from previous employers are an important part of good recruitment and selection practice”.

Some managers felt that time differences, especially between most migrant home bases such as India and most African countries, made it doubly challenging to secure references for job applicants: “because of shortages at work, sometimes you end up trusting the applicant’s word and you employ them without any reference checks”. However other managers said that they had noted that the severity of this problem was lessening due to improvements in communication technology. Lindsay said that at her facility, they had made a conscious decision not to worry so much about references of the migrants considering the low level skill-sets requirements for the carer job.

Other managers said that they had since discovered that most of their migrant applicants had friends who were already in the industry or working elsewhere in New Zealand. These managers therefore phoned these friends to obtain references. However some of the managers raised concerns about the credibility of the character references that were obtained from friends and colleagues of the migrants applicants.

From a quality care delivery perspective, all the managers, who had experience of employing migrants without obtaining credible reference checks, said that they had never had unsavoury situations with the migrant workers they had hired. The majority of the managers echoed the
view that the migrants always worked very hard and never presented any untoward behaviour at work. For example, manager Lindsay said that “I used to worry about reference checks... Now I just use any name they give me when they come for interviews... I have never had issues with my foreign workers... their behaviour is in most cases beyond reproach...”

The managers are divided about the value of reference checks, but on the whole the majority were of the view that the migrants had enhanced quality care delivery even though the managers may not been able to do a thorough reference check.

7.2.3 Visa issues and quality care delivery implications

Perhaps more significant were the perceptions of the managers about the implications to quality care delivery in light of the prevalent problem of visa renewal refusal or delays by New Zealand Immigration. Manager Dakota said that she had noticed that the visa renewal problems were contributing to compromised quality care delivery. She said that some of her residents were not happy to deal with ‘new faces’ on a regular basis. “Once they get used to a caregiver, they seem to develop some form of attachment... most of the migrants that I have employed before tend to be so dedicated to their job... these old people easily develop a sense of attachment to their caregivers...” She said that she had noticed that some of her residents appeared “unsettled and agitated” every time they learnt that their carer had left the facility’s employment.

In the same vein, manager Bailey said that “the job of caregiving is too personal... people make relationships here and when the carer leaves, the other part may not take it lightly... This goes both ways... when the patient passes on, the carer – migrant or not... is affected as well...”. In agreement, manager Madison said that she had noticed that most of her migrant employees were very good at creating relationships with the patients: “Sometimes these old people abuse them [migrants] but they rarely take it personally... I guess that is why the patients quickly warm up to them...and also take it so hard when they leave”.

Connected to the visa issue, is the problem of high turnover that some facilities are experiencing, which in turn makes it difficult for aged care facilities to remain competitive, since they have to continue training new staff to enable them to deliver quality care to their standard. The literature on strategic human resource management makes some telling contributions in relation to this subject. For example it is argued that the profile of employee behaviours necessary for companies pursuing a strategy of quality enhancement include:
“relatively repetitive and predictable behaviours, a more long-term or intermediate focus, a modest amount of cooperative, interdependent behaviour, a high concern for quality, a modest concern for quantity of output, high concern for process “how the goods or services are made or delivered”, low risk-taking activity, and commitment to the goals of the organization” (Schuler and Jackson, 1987, 209).[original emphasis]

High turnover caused by delays in processing visas can have huge implications for quality care delivery since it forces the managers to hire new employees in short periods of time. Harrington (1996) stresses that there is a relationship between turnover and patient care, and argues that higher turnover interrupts continuity of care and is associated with lower patient care outcomes. It is always going to be difficult to achieve high quality care delivery which associates high quality care delivery with repetitive behaviours, modest amount of cooperation and a high concern for quality. In the same vein Ulrich, Halbrook, Meder, Stuchlik, and Thorpe (1991) found a significant relationship between the tenure of employees and customer satisfaction. Transmitting these values into the workers takes time and high turnover does not seem to help. High turnover means that employers do not get enough time to socialize new employees into the culture and practices of the organization. In this regard, high turnover does not support the development of such skills and behaviours in the worker. It can also be argued that high turnover is not consistent with employment patterns that support high quality care delivery.

7.3 Underemployment: “the problem of excellent CV’s”

The managers appeared split about whether or not some of the migrants that they employed, who were in possession of high qualifications, impacted negatively or positively on quality care delivery. In this regard, Table 6.2 in Chapter 6 shows that the majority of migrant carers have in their possession relatively high qualifications mostly obtained in their home countries, albeit in other sectors of the economy. Table 6.2 shows that the majority of the migrant carers have completed diplomas, and a few had in their possession Masters Degrees. Some of the migrants, especially from India and the Philippines, were qualified nurses waiting accreditation to be allowed to practice nursing in New Zealand. A few of the migrants however had, a high school certificate as their highest qualification. The group of migrants that is made up of students has not been considered in this study as fitting the tag of underemployment, because they are mostly doing carework to supplement their student
allowances or scholarships. However, it is also interesting that there are no native New Zealand born students working as carers in the facilities that were part of this study.

All the managers said that they had observed that the majority of their migrant cohort of careworkers possessed high qualifications not necessarily to do with the caring of the elderly patients. Manager Bailey had noticed that most of the migrant carers had some “excellent CV’s, never mind that these qualifications are not health care related”. Manager Madison said that she had noted on the migrants’ application letters that that some of the migrants had previously held some very prestigious jobs in their home countries. The managers also noted that the migrants CVs reflected that most of them had studied up to degree level in their home countries. One of the most interesting views expressed by all the managers who had employed such ‘highly qualified’ people, was that, ordinarily, most of the managers did not expect such people to work as careworkers. In this respect, manager Emerson said that “in my whole experience as a manager here and elsewhere, I don’t remember ever employing a New Zealander in possession of such qualifications...” All the managers therefore perceived that it was easier for the native people to secure a job that they were trained to do than it was for the migrants.

The managers also agreed that some of the migrant levels of education made them totally unfit for carework: “This job is important... but frankly speaking, it does not require one to be as educated as most of the workers I have here from other countries”, said manager Christian.

In this regard, manager Madison had some very interesting views about this subject. She said that in a normal environment, people upgrade their educational qualifications so that they can assume better job positions or “management positions where they supervise others doing the work ... if the truth be told, I am sure that the ambition is not to do a job like this ... If anything, the aim is to move away from such manual low paying jobs”. She said therefore that there was indeed, with most migrants, a mismatch between the tasks associated with carework, and the qualifications in the possession of these migrants. She also said that she understood the “frustrations of these highly educated people when they go to a foreign country and can’t get a job they are qualified in”. In the same vein, Cameron, said that she ‘sympathised’ with such people who found themselves doing a job that had nothing to do with their educational qualifications.
Extant studies echo the managers’ views by arguing that in most cases migrants experience class and occupational downward movement from upper or middle class jobs and positions in their home base, to lower status as migrants carers abroad (Parreñas, 2000, 2001) that comes with being employed as a careworker.

7.3.1 Under employment and quality care impacts

An important issue in this context was the perceptions of managers about the impact of underemployment to the delivery of aged care quality by migrants. In this respect the managers echoed each other in the view that they had no evidence that the “over qualified” immigrant carers’ behaviour in the discharge of their duties was in any way negatively influenced by doing a job “beneath one’s educational qualifications”. In this context, Lindsay said that she actually believed that the migrants, who were in possession of higher educational qualifications, although not necessarily to do with the healthcare industry, appeared to have many “useful and important transferrable skills”. She noted that some of the migrants she had employed had qualifications in business management and people management related courses. She believed that these people had applied their knowledge and training in other fields to their advantage in forging good relationships with the patients. These findings contradict extant literature that associate underemployment with low job performance. Some studies have, for example, argued that underemployed individuals will not perform at their optimum because they find their jobs pointless and demotivating (e.g., Borgen, Amundson, & Harder, 1988).

The ability by some underemployed highly qualified migrant carers to adapt prior skills to create good relationships with aged care patients is especially significant when considered from the viewpoint of how elder patients, as recorded in studies elsewhere, perceive quality care delivery. For example, Chapter 2, Section 2.2.1 of this study gives the example of a study conducted in the USA by NCCNHR which found that the residents rarely identified clinical care as the most important factor in their quality of care or life. On the contrary, the aged patients reported that pleasant and positive relationships and feelings and attitudes between staff and residents are crucial to quality of life and care. These findings show that underemployment has enhanced quality care delivery, as some highly qualified migrant carers have adapted their prior skills to the care sector.
However, manager Lee, said that she had observed that most of the migrants with high qualifications in other economic sectors took a long time in adjusting to the job of caring. She also noted that they took time to create relationships with their patients. She perceived that this could be due to the shock of doing a job that, given their high qualifications; they would have not ever considered doing in their lives.

In the same vein, manager Madison said that the elderly patients “can be a difficult lot... they need a patient and strong person to deal with them...”. Echoing the same view, manager Cody said that “the job of taking care of these elderly people is not for the faint hearted... this is a demanding job...some of these people are very frail and can’t do anything on their own”.

Although all these conditions affect carers of all nationalities, native or foreign, they assume a greater significance when considered from the viewpoint of underemployment, which mostly affects migrant carers in light of the statistics as shown in Figure 6.2.

This significance is better appreciated from the viewpoint of Lee, who, in her musings and sympathies with the plight of migrants that find themselves taking up jobs as “ordinary carers”, reasoned that as one acquires higher qualifications in the course of their life, they also climb up the social ladder, and some jobs stop featuring in one’s thoughts about the career path to take. She said that she believed that being an “ordinary carer” was one of such jobs. This view resonates with other managers’ characterisation of carework as a career that one could not ordinarily “proudly talk about to friends” as is the case with other jobs in the health sector.

In this regard, some of the managers felt that the mismatch between the qualifications of most migrant carers and the nature of tasks that characterise caregiving could be one of the reasons why most of the migrant carers appeared to be in shock when the managers took the migrants around, during the orientation and induction process, to show them what would be expected of them as carers. Manager Casey succinctly summed up the complex characteristics and nature of carework which she surmised could be what shocked most of the migrant applicants when they were exposed to the caregiving job details for the first time:

“Some of the tasks that have to be performed on a day to day basis are things many of us rarely want to do... except maybe when the person involved is your child... The workers here deal with very difficult tasks some of which may pose a health risk if one does not follow proper procedures... it’s a hard job... we have a responsibility to look
In this context, Casey said that she could tell that as she showed the new migrant workers the process of providing care to the elderly such as bathing, or cleaning them after they have soiled themselves, as well as feeding them, some of them appeared “visibly shaken”. She said she had experienced situations where the new migrant worker did not turn up the following day after initial induction. She believed that although some of her native employees had also been shocked at being exposed to the nature of the activities that are performed in caregiving; the situation was different compared to the migrant carers or applicants. Manager Casey said that she had discovered later from other migrant carers that most of them are rarely exposed to such activities, nor do they perform such activities in their countries.

Manager Bailey said that she “sympathised with most of the migrants because some of them come from environments where rest homes are not that common…” To this end, Cody suspected that the migrants who came from countries that did not have a formal system of care for older people in place “would naturally be shocked to see a house full of old people as we have here”.

These reactions of the migrant employees are very interesting especially when considered from the viewpoint of culture. It can be argued that this show of ‘shock’ points to the nonexistence of ‘common cultural spaces’ (Couldry, 2000) regarding conceptualisation of care and the specific tasks that are involved. In this respect, a study conducted in Australia discovered that different cultural groups reacted differently to the performance of caregiving tasks such as personal care, showering, dressing and toileting (Cardona, Chalmers and Neilson, 2005). Previous research on carers has highlighted that there are differences in terms of cultural perceptions of care and family responsibility (Thomas, 2003). Unpacking these issues is important to understand the extent to which cultural values determine the outcome of interactions between carers, managers, and other related service providers (Cardona et al., 2005) and perhaps, contribute to the treatment of ethnicity and culture as enablers, and not problems or barriers, militating against the delivery of adequate care to the elderly.

With regard to quality care delivery, most of the managers noted that it took longer for most migrants to get used to their clients or to fit into the system. The managers also noted that
most migrant carers took longer to warm up to the idea of cleaning soiled patients, even though this is an integral part of caregiving. Other managers felt that it was in fact the patients who took longer to get used to the new migrant carers. However all of the managers said that once the migrant workers got past the initial shock most of them are “excellent at what they do”.

The other managers said that they had noticed that such ‘highly qualified’ people were not enthusiastic about studying to obtain aged care professional qualifications such as Aged Care Education (ACE) and Career Force. This was despite the fact that those who went through the programme were rewarded with relatively higher wages. Cody, perceived that the migrants who were not in possession of higher educational qualifications did not hesitate to take up these courses. Dakota, however said that she had noted that very few of their migrant workers, educated or not, appeared interested in doing the ACE and Career Force qualifications. She perceived that the workers did not find the reward of attaining the qualification attractive enough. A few of the managers however said that since they paid the expenses of doing the ACE programme for their employees, they had since decided to stop recommending their employees to do the ACE programme because it was becoming too expensive.

Some managers said that the migrants they employed were mostly students pursuing other studies at the local University of Otago and Otago Polytechnic, some of them with career trajectories that had nothing to do with the aged care sector. Student nurses doing carework did also not see the value of attaining ACE or career Force qualifications.

Although they could not categorically say that the performance of those in possession of aged care sector qualifications such as ACE and Career Force was better than those without. They believed that there was value in obtaining these qualifications since they had been put in place to teach the important details associated with properly providing quality care to the elderly. Cody said that the on-the-job training they were giving to the migrants needed to be complemented with these recognised aged care qualifications.

From a quality care delivery perspective, the managers were unanimous that these low level qualifications (ACE and Career Force) were useful in improving quality care delivery and the reputation of the facility. Those who went through the course were given badges that identified them as qualified nurse aids. Christian perceived that their patients had confidence in their carers’ abilities to take care of their needs, especially when they saw them putting on
The ACE badge. The managers said that their patients’ family relations also believed that a carer with an ACE badge or some other badge was capable of taking care of their institutionalised aged relation. The ACE or Career Force badge had some marketing and quality assurance role to play in the facility.

A significant point emerging here is that most managers seemed not to appreciate the challenges of underemployment, a characteristic that in many ways aptly captures the profile of most migrants who take up carework as a job in Dunedin. Their inaction is understandable in light of comments documented earlier to the effect that the majority of the managers believed that the employment of migrants had not compromised the facilities’ ability to deliver quality care to the elderly (see chapter 6, Section 6.9).

These managers’ responses still require further scrutiny from the viewpoint of literature perspectives on the impacts of underemployment on job attitudes and job satisfaction. Whilst at one point the managers unanimously agreed that migrant employment had not compromised care delivery, in other responses, the managers expressed statements that contradicted such characterisations of the migrants’ role in quality care delivery. For example, it in the preceding paragraphs it is reported that that the some managers had observed that most of the highly qualified migrants were taking longer times to get used to the job as well as creating close relationships with the elders.

The actions of these migrant carers can be explained from an underemployment theoretical perspective. Several studies support the view that underemployment has a negative impact on job attitudes (Burris, 1983; Feldman & Turnley, 1995). In the same vein, it has also been documented that employees that have high expectations with respect to job challenge, tend to experience lower job satisfaction when they are tasked to carry out unchallenging assignments (Khan & Morrow, 1991). It could however be argued that the actions of the migrants is due to culture differences or English language proficiency difficulties.

The impact on job performance resulting from a migrant worker’s realisation that the care sector lacks opportunities for personal training and development assumes greater significance when considered from the perspective of how elder patients define quality care. In this case, it is difficult to raise a coherent and lucid argument that would support a scenario in which a dissatisfied worker will successfully put on a professional persona that is consistent with behaviour patterns that are necessary in delivering aged quality care, especially considering
the intangible dimensions such as attitude, genuine concern, tone of voice that elderly patients use to characterise quality care. The quality of hard or manufactured products such as computers, tables, and chairs cannot be compromised by a surly and discourteous sales person. Production and consumption can even be separated with such products. However, with care services, it is important to note that they are largely characterised by real time delivery, where production and consumption cannot be separated. The literature on service relationships emphasises that quality care is defined by the nature of relationships that are created between carers and carees. The longer time that is taken by some of these migrants to create close relationships with the aged patients, may also be interpreted as reflecting bad quality care delivery. In this regard, it can be argued that these findings support the extant studies’ position to the effect that underemployment can be a double edged sword with both positive and negative impacts on job performance and quality outputs.

Because of the highly interactive nature of elder care provision and consumption, some insights can also be drawn from the resource-based view of organizations, and the role of HRM in enabling firms to achieve sustainable competitive advantage. The resource-based view of organizations focuses on firm resources that can be sources of competitive advantage within the industry (Barney, 1995). To this end three basic types of resources have been singled out as being capable of providing competitive advantage. These are (1): the physical capital resources, such as the firm’s plant, equipment, and finances, (2): organizational capital resources such as the firm’s structure, planning, controlling, coordinating and HR systems, and (3): the human capital resources such as the skills, judgment, and intelligence of the firm's employees (Barney, 1991).

It was however suggested earlier on that sustainable competitive edge in the care sector is more achievable through the utilisation, and not exploitation, of human resources. This was because of the dimensions that elderly patients use to characterise quality care. The underemployment of carers and the lack of training and personal development opportunities for them therefore do not bode well for quality care delivery in the long term.

**7.4 Carework characterisations and occupational stress.**

Yet another significant aspect of the managers’ responses showing their perceptions of the challenges migrant careworkers encounter, can be deduced from the manner in which they described carework. As discussed in the previous sections, most of the managers described
carework as ‘stressful work’, ‘difficult’ ‘hard’ and ‘poor paying’ ‘not for the faint hearted’ and also requiring the person doing it to ‘exercise patience’ in the midst of the challenges. It is important to note that these issues are not unique to the migrant carers. However, as described in the preceding paragraphs, some of the managers perceived that the nature of the activities that are done in caring for the frail elderly patients appeared to have been more challenging to the group of migrant carers compared to the indigenous group. The managers also, as recorded earlier, sympathised with the position of most migrants who found themselves doing jobs beneath their qualifications.

In this respect, manager Casey, said that “I can only imagine the kind of stress some of these foreign workers experience... I would also definitely be stressed if I found myself in this position”. However Christian said that the stress the migrants could be experiencing was not caused directly by the nature of the tasks that they were doing but was caused more by the anxiety about when they were going to be able to secure a job that they were trained in. She believed that any person could be stressed by doing a job that was beneath their training regardless of how easy it was to perform the tasks of that job. In her view the fact that caregiving was characterised by some difficult tasks was beside the point. She also believed that most of the migrant workers appreciated the financial benefits they derive from the job.

A more interesting dimension to this question had to do with the perceptions of the managers about the manner in which their migrant employees were handling the pressures that are associated with the nature of caregiving, and whether their reactions had any impact on the quality of care delivered. There was unanimity in the view that it was difficult to tell whether the actions of the migrants in the delivery of care were being influenced by the stresses they were experiencing from the job situation or from their private social lives. Manager Casey concisely summed up this issue when she said that

“I have had situations in the past when the patients complained about the behaviour of some carers... they felt that the workers were not polite or did not talk much to them..., we encourage our workers to talk to the patients and explain to them everything they will be doing to them... I guess when a worker goes about showering the patients without saying a word to them, one could say that the person is dealing with some problem... yes this could be stress related to the task they are performing or it could be because of something else totally unrelated to the job... it’s difficult to say...”
Bailey also echoed these views when she said that she had walked into a room and found the carer who had always come across as “cheerful and bubbly” talking to “one of our difficult patients in a very harsh tone. I could not understand most of what she said, because she was speaking in her own language... I could however tell that she was very angry... the tone of her was not good at all... the moment she realised I was in the room standing behind her, she changed and started speaking in English in a very polite tone... mood swings are not good for this industry... these old people need caring people.. I know they can be difficult... but they are old people... what do you expect from them?”, she rhetorically asked.

She however could not categorically link these “mood swings” to stress caused by the nature of the care job. She however added that she rarely had had any complaints from her elderly patients about local New Zealander carers being abrupt or not making attempts to engage in conversation with them when performing various caregiving tasks.

7.5 Language and Communication barriers: English proficiency

In light of the personalised and generally intensive nature of the caring relationship between age patients and their carers in general, it was necessary in this study to record the perceptions of the managers regarding the language and communication challenges or difficulties that mostly characterise migrant carers in their interactions with managers, co-workers and the patients. The subject of communication is of great significance to quality care delivery especially when it’s considered that aged care patients consider their interaction with carers as one of the most defining features of quality care (see Chapter 2 Section 2.21). From a soft HR perspective, communication appears to be one of the central issues that managers should worry about in their training and socialisation of new employees. It is argued that “greater potential for sustainable competitive advantage stems from investments in firm specific skills” (Barney & Wright, 1997, 13) since these skills can rarely be duplicated by competitors.

To this end, all the managers that were interviewed shared the view that there were significant challenges with most of the migrant carers’ oral and written communication skills. All the managers largely agreed that English language proficiency was a major barrier to communication for migrants. In considering the significance of these views of managers regarding the role of language proficiency in quality care delivery, it is important to note that a number of studies are of the view that proficiency in communication is a fundamental factor
that impacts on the quality of interactions between the carers and the caree, and ultimately, the quality of care (Johnstone and Kanitsaki, 2008; Xu, 2008). Previous studies also show that residents believe that carers have to be trained in communication skills in order to interact better with them (National Citizens’ Coalition for Nursing Home Reform, 1985).

Communication is a very significant variable in the definition of quality care. This is therefore obviously an area of concern for managers of aged care institutions that are relying more and more on the migrants to deliver care to the elderly.

Impediments in communication skills hindered the ease with which the migrant workers interacted with managers, co-workers as well as elderly patients. Drew, in this regard said that “migrant care workers with poor English language skills represent a significant cost to the organisation due to the time spent orientating them and training them”. Lindsay, perceived that the limitations of the migrants regarding English language proficiency were magnified by the fact that carework “is a delicate job that requires that instructions are followed to the letter”. She said that she had noticed that some migrants struggled to produce clear and understandable accounts of what would have transpired during their shift. Casey said this was especially worrying because carework reporting requires that all significant and seemingly non-significant occurrences are captured to enable the next person to discharge of their duties effectively and efficiently. In support, Bailey said that “a worker who could not communicate well on paper and orally represented a significant risk to the quality of care provided to the elders and ultimately to the organisation. Bailey added that a simple mistake arising from poorly written accounts of the day’s happenings could cost the life of the patients some of whom she described as ‘frail’ and requiring diligent care from and carers to detail to avoid committing mistakes. An employee that had limited oral and written communication skills was generally perceived as a significant risk to the facility in its attempt to cater for the needs of the elderly.

In this regard, some of the managers made references to a certain ethnic group of migrant carers whom they considered to be “very hard working and dedicated to their jobs” but also seriously challenged in their English language communication abilities. They believed that this had repercussions on performance management and monitoring. For example, Cecil said that she had noticed that people belonging to this certain ethnic group seemed “to agree with everything you tell them... They nod in agreement and give you the impression that they have understood everything you would have talked about...”
Emerson said that it was important for new carers to question when they did not understand because that was the only way they could ensure that quality care standards were adhered to. Emerson said that there was a threat to the quality of care delivered by such unquestioning people: “you may think that you have made yourself clear to them when explaining how the work is done because some of them just nod enthusiastically... however, when they do the job, you realise that they did not understand your instructions”.

In the same vein, manager Dakota said that in her experience with migrant care workers, she had discovered that there were some people from a certain named country who seemed to think that it was wrong to disagree with the manager. However, in practice, the manager said that she had noticed that these people tended to do the opposite of what you would have talked about during induction and training. Madison said that this made it difficult for managers to know what do in order to avoid carers acting in a manner that could be costly to the lives of the patients as well as the organisation. Christian thought that because migrants “badly want to keep their jobs”; they perceived that disagreeing with a manager would jeopardise those chances. To please the managers, some of the migrants therefore tended to overstate their knowledge and skills about their ability to perform some carework tasks.

However, Christian said that no serious accidents had happened due to this problem of trainees appearing to have understood all instructions. In the same vein, Emerson said that nothing untoward had actually happened as a result of this problem of poor communication, but she thought that it was just “an accident waiting to happen” in light of the delicate nature of caregiving.

In order to appreciate the behaviour of some of these workers, it is important to note the central role of culture, since culture underlies every aspect of social behaviour and helps to define the rules and patterns of each language (Rau, Li & Li, 2009). In this regard, it is argued that an individual’s communicative behaviours are reflective of one’s language and culture (Patricia, 1997). In the same context, Hofstede characterizes the culture of countries using the dimensions of power distance; individualism/collectivism; masculinity; and uncertainty avoidance. Hofstede’s study argues that some countries are defined by ‘Large Power Distance’. People from such countries expect inequality and power differences, centralized authority autocratic leadership, paternalism, and acceptance that power has its privileges. Individuals who come from ‘Small Power Distance’ societies are used to decentralized authority and decision making responsibility, lack of acceptance and
questioning of authority, rights consciousness and a tendency toward egalitarianism. This contrasts with lower power distance countries, where there is a preference for consultation and subordinates are happy to approach and contradict their superiors. This could explain the behaviour of some of the employees the managers had identified as not being interactive enough. Migrant carers who come from high power distance cultures will behave differently from their managers who might come from low power distance cultures as illustrated in Figure 7.1 below. People from low context cultures may perceive the same issue differently to those who come from high context cultures.

The moderating role of culture in the interactions between the managers and their migrant employees deserves more attention from both parties, but more so from managers (See Chapter 8 in which the study recommends diversity training for managers of aged care facilities). It is interesting to note that a few of the managers interpreted the silences of some of the migrants as being caused by their desire to ‘keep their job or to impress the managers’. This explanation seems weak in the face of Hofsted’s theorisation about culture and its role in shaping social and communicative behaviour.

![Table of High and Low Context Cultures](image)

**Figure 7.1 High and low context cultures**

Source: Jandt, (2004, 62)

The conflicting interpretations of behaviour presented in the preceding paragraphs reflect the role of culture in moderating behaviour patterns as well as interactions between diverse cultural groups. It cannot be discounted that some of the migrants come from countries where
there is a culture of high power distance (Hofstede, 1991). In high power distance countries and organizations, people do not question the decisions of their leaders or supervisors. Subordinates will rarely articulate disagreement with authority fearing consequences of conflict. A case in point is the manner in which the managers interpreted the responses of some migrant recruits in which they did not ask questions during orientation, or gave the impression that they understood instructions, yet in practice they showed that they had not fully understood the instructions.

Another challenge that is closely related to the English language proficiency of the migrants relates to the perception by some managers that “the tone and accent of some migrants” contributed to communication challenges. They said that most of the elderly were not used to the different accents and sometimes this made them lose their patience with their carers. Some managers singled out a certain ethnic group of migrant care workers from (named country) who “talk too fast” which made it hard for elderly residents with hearing problems to understand them. In this respect, one manager said that

“We have had problems in our dementia unit where our residents are old and suffer from memory loss and sometimes they speak incoherently... communication is a big issue especially with English being a second language for most of the migrants”.

On the other hand, some managers said that some of their migrant careworkers had very high English language written proficiency skills as they could write very clear accounts of the day or shift’s events. These views are echoed in findings of a study done on migrant workers in New Zealand by North (2007) in which 98.1 per cent of employers in New Zealand were reported as stating that the English language of immigrant employees was adequate for the job. However, these workers still presented problems because in some cases their accents did not do much in aiding communication. In this regard, a study done in the UK by Cangiano et al., (2009) found that knowledge of the English language, and the ability to understand and distinguish the various dialects, accents and colloquialisms, remained the most frequent source of difficulty for residents and care workers. Some of the managers however perceived that the different accents did not affect the quality of care since the migrants were able to talk to the resident, which ultimately is what matters most. Madison, however was of the view that what mattered most was the “attitude and not the accent”. She reasoned that a patient was more likely to be impacted negatively by a carer
whose attitude was negative even if that same carer used an accent that the caree was used to, compared to another carer who might use a “heavy accent” but show a very positive attitude to the patient.

These findings reflect that the managers are split regarding whether or not accents and voice tones impact negatively on quality care delivery.

7.5.1 Coping with communication challenges

Most of the managers who made reference to language challenges however, made it clear that language barriers could be overcome. The managers coped with the communication problem in different ways. Some said that they tried to eliminate this challenge at the recruiting stage. Some of the managers said that they did not employ any one they felt would not be able to communicate or understand what the residents were saying. Some of the managers said that they used the interview stage of the recruitment process to check the level of English language proficiency and other communication skills. The recruitment stage was therefore seen as strategic in screening those recruits that were likely to present huge communication challenges. In this context, Cody said that she did not have communication problems at her work because:

“When I do the interviews, that is the time I do my screening... if I go ahead and give them a job, that means I am confident with their English. They communicate well... there are no issues around this at this facility...”

Manager Lee, however, said that she did not put too much weight into the communication skills of the applicant at the recruitment stage. Her strategy to improve the skills of the migrant carers hinged on facilitating the integration of the migrants with the local employees once they started work. In this way she hoped that the migrant worker could benefit from speaking with the local employees at work. She therefore paired migrant with locals in her shift management.

Some managers said that they encouraged those among their workers whom they perceived to have “accent issues” to make attempts to speak slowly. Cameron said that “speaking very fast” was a problem for everyone including the native careworkers. Her strategy was simply to emphasise to all her employees the need to make sure that the other party involved understood what was said.
Some of the managers said that their elderly patients were now getting used to hearing different accents because in most cases the people caring for them were migrants. They were therefore not as concerned about the accent of the carer. In her view, the accent of the migrants was no longer presenting significant challenges in the communication process between carers and patients or carers and managers as was the case when they started employing migrants as carers.

A significant point emerging from the views of managers relates to the help that could be put in place to improve the English language proficiency of the migrants. Most of the managers did not have a strategy in place to help their migrant workers to improve their English language skills. The exception however, are Lee and Dailey who made a conscious decision to pair native and migrants carers as a way of improving the English language skills of the migrants.

7.6 Orientation, induction and training migrant care workers

In light of these communication challenges and other challenges emanating from the cultural differences between migrant carers and their new place of abode, perhaps another important area of concern relates to the strategies the various managers used to help their migrant workers to adjust to the tasks of caring for the aged, and the general new working environment. In considering the views of managers regarding training and professional development of carers it is important to note, as argued elsewhere, that HR practices can create value for a firm when the individual practices are aligned to develop critical resources or competencies (Wright, Dunford, & Snell 2001).

In the same vein, it is argued that that the employee based capabilities, built and sustained through HR practices, tend to be difficult to emulate since they may be specific to the organisation in question, as well as being socially complex and path-dependent (Lado & Wilson, 1994). If the delivery of quality products depends on predictable and reliable behaviour from the employees, training costs seem therefore to be unavoidable, especially in cases where there is high turnover.

Most of the managers said that they treated all new recruits similarly and therefore made them go through a generic induction and orientation programme. Some of them seemed to suggest
that a unique induction and orientation programme for migrants was similar to practising segregation or unfairness at work. Most managers did not view migrant worker as deserving of some uniquely tailor-made programme that took account of the background characteristics of the migrant workers, especially as a way of helping them to fit into the service culture of the organisation. In this regard Baily said that “It is difficult to establish parallel training or orientation programmes for locals and natives… One runs the risk of being accused of practicing discrimination or favouritism…”

The majority of the managers therefore subjected their new migrants to a three-day-orientation programme. The new recruits were also attached to a buddy, known as a preceptor. Some of the managers said that they also paired the new recruit with a senior carer who gave managers feedback. However, a few managers said that they made their migrant careworkers go through an extended period of orientation in order to raise their confidence levels regarding the discharge of carework duties. At one facility they held a class for orientation with the new staff that ran for about 3 months as a follow up to the initial orientation. This was to check if there was need for more information to the new staff and also to see if they had settled well.

Some managers had resorted to using more established migrant workers to train the new migrant employees. However, one manager said that she had noticed that some of the established migrants workers had low communication skills and could not interpret the meanings contained in the written orientation manuals:

“We however have a problem with the migrant carers training other local carers because you have some who are really good at their work but the language becomes a problem when training other new staff. We are working on this”.

Another interesting dimension of the orientation programme emerges when one considers the manner in which it is conducted, especially with reference to its packaging. All the managers said that they had pre-prepared ‘Orientation booklets’ which contained information that was deemed important. These booklets were therefore given to the new recruit to read on their own. The books contained generic information that was not necessarily targeted at the migrants. One of the managers said that she had come up with a pre-employment day where the new recruit accompanied a senior member as they went about their daily elderly care chores. She said this exposure was important as it gave the new recruit an opportunity to
decide whether or not they were prepared to do the job. The manager said that in light of the nature of dementia patients, she had devised a 5-day orientation for new recruits regardless of origin. Two of the managers disclosed that they had devised a much longer orientation programme in which the new recruit would go through an initial 10 day orientation, followed by three days exposure in each of the departments of the facility.

From an HRM perspective, mentoring is generally perceived as one of the most effective ways of managing diversity. It is suggested that a successful senior mentor be matched with more junior workers or minority employees, with the objective of enabling under-represented demographic groups to move through the invisible barriers and advance in their careers (Ragins, 2002).

All the managers shared Christian’s view that “Our training and orientation programmes are generally effective...most of our new recruits do very well after the training... I can say that our programmes are crucial to the delivery of quality care to our patients”.

The managers also described their training and orientation programme as useful in helping the newly recruited employees to get used to the environment as well as the job tasks and elderly patients. The managers disclosed that they also used the orientation process to determine and identify future training needs of that person, and if someone was trainable or not. They complained as discussed earlier on about the huge challenges related to understanding whether or not their new recruits had acquired enough skills and job knowledge to be allowed to do the job with minimal supervision. Some of the managers had noticed that most of the new migrant recruits were not comfortable asking for more information. The managers perceived that the migrants assumed that asking many questions could lead to them being viewed as people requiring a lot of attention or supervision. The managers thought that some of the new migrant recruits kept silent in order to create the impression that they were able to work independently and that they were fast learners.

The managers were aware of the role of training on the image of the organisation. They echoed each other when they stated that training was the most important activity to ensure quality care delivery. One of the managers said the quality of the staff at each facility reflected on the image of the manager: “if one was running a place, why would they not train their staff? People see the manager or facility through the staff employed”. 

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The other managers said that they were required by law to train their staff since training was part of the requirement of the Ministry of Health. Without a well trained workforce it would be hard to pass the quality audits conducted by the Ministry and other stakeholders of interest. In this regard, an untrained employee was described by one manager as “an expensive mistake”.

A significant feature of the managers’ responses regarding training, induction and orientation of new staff, is that none of the managers approached these activities with the ‘migrant care worker variable’ in mind. At most of the facilities there is therefore no training specifically for migrants since most of the managers described the migrant workers invariably as “not different from the other carers”.

The managers’ approach to training and orientation for migrant carers brings to light the debate on Equal Employment Opportunity (EEO) or specifically the problem of assumptions associated with the concept of EEO. It is argued that “The discourse of EEO represents the major and critical attempt to address issues of inequality in employment …” (Jones, 1995, 97). EEO, is concerned with changing for the better the work experiences of members of disadvantaged groups (Webb & Liff, 1988). Central to the discourse of EEO are terms such as ‘equity’ ‘equality’ ‘fair’, and ‘sameness’ (Humphries & Grice 1995, 206). In this regard, the Human Resources Managers are mandated with the task of ensuring equality of opportunity is available to all individuals. However, some argue that that human resources procedures cannot be relied on to produce equitable outcomes (Webb & Liff, 1988). There are therefore problems with the implementation of EEO. For example, a liberal perspective of EEO would solve “discriminatory employment access, opportunity, condition and outcome by creating fair procedures and employment practices for individuals by individuals, emphasising fair practices for recruitment, selection, appraisal and promotion” (Brooks, Harfield & Fenwick (undated, 7). This may explain why managers have not approached the training of migrant carers differently from that of indigenous co-workers. By crafting specific professional development programmes for migrants, the managers run the risk of antagonising their local and migrant carers. The locals may perceive that the migrant carers are being preferentially treated.

The radical view of EEO however demands that employers recognise the specific needs of a minority group. Radical implementation of EEO includes manipulation of employment practices for positive discrimination as part of government legislation, or coming up with
some form of Affirmative Action that will allow the devotion of ‘sufficient resources’ to ameliorate a perceived lack in a specific group (Kramer, 1993). Migrant carers could be considered a special group that requires such help, especially in light of the fact that most of them possess high qualifications in other sectors of the economy but these qualifications are rarely considered competitive enough in those sectors. With reference to Canada it is argued that the reasons for foreign work experience being “heavily discounted range from discrimination and racism based on country of origin, to ignorance about the value migrants’ experience could offer an organization (Suto, 2009,18).

7.7 Employee relations and cultural differences

Another theme that is closely linked to communication challenges of migrants, relates to the views of most managers that migrant carers tended to keep to themselves and take a long time to integrate with others. In this regard, extant studies have observed that impairment in language and communication abilities can affect social integration of foreigners with co-workers of other nationalities (Chiswick & Miller, 2002). In the same context, Walsh and O’Shea (2010) argue that language can hinder workplace and wider social integration.

In the context of quality care, all the managers seemed to share the view that it could only be guaranteed if the care provider groups, that is, managers, carers and patients, exhibited few conflicts. In this respect, managers perceived that most of their migrants tended to keep to themselves and did not show enthusiasm to interact with their Kiwi partner carers. Concerns were therefore expressed by a number of managers about some of the migrant careworkers who were said to be “lonely and isolated” who were basically on their own most of the time and did not integrate well.

In this regard, Christian said that she had also noticed the emergence of groups that had a nationality dimension to them. Christian also perceived that migrants stayed in their groups that had a nationality dimension because these groups made them feel safe, as well as enabling them to develop a sense of belonging. In the same vein, Emerson surmised that this was one of the reasons why most migrants found it hard to learn the local culture as well as improve on their English communication skills. The emergence of nationality-based groups was also perceived to be the cause of some conflicts between especially migrant carers and other co-careworkers. Christian said that “I have also noticed that most of the migrants form
groups according to where they come from and sometimes there are conflicts between these people and other carers... nothing serious though...”

Lindsay said that she was not “necessarily worried about the formation of these groups... I think its natural... what worries me is that once in these groups, they converse in their own native language which cannot be understood by others... this is not right”.

In this regard, Lee said that, “… We have to accept responsibility for some of the actions of our foreign born workers... I don’t think any of us can claim to have a thorough understanding of each other ... Perhaps as managers, we have failed to create an open environment for them to share their concerns with us... it’s any one’s guess…”

Most managers had also noticed that in comparison to migrant carers, their cohort of native carers seemed more open and upfront with any of the issues they found disturbing at work. Some of the managers therefore suggested that perhaps the employees were not opening up to them because they had no faith or confidence and trust in management to deal adequately with their problems. In this respect, Cecil said that, “We can’t rule out the possibility that we may have failed as managers to create an atmosphere that encourages them [migrant carers] to walk into our offices and complain about issues they are not happy about”.

The difference in behaviour between migrants and native carers can also be explained from the view of ‘culture’: “the mental software for humans, which play a significant role in forming our ways of feeling, thinking, and acting” (Hofstede & Hofstede, 2005, 1). Migrants who originate from counties that are defined by ‘high power distance’ may face challenges operating in cultures that have ‘small power distance’.

A more serious concern from the viewpoint of aged care quality delivery in this regard, is the observation that some of the migrants had developed a tendency of speaking in their own language even when interacting with the elderly patients.

It is important here to note that the views of managers about what constitute ‘quality care’ echoed the reviewed literature’s definition of quality care. In the discussions with the managers, the terms that kept on coming out in their definition of quality care were “good attitude, professional appearance, tone of voice, facial expressions, cheerfulness, showing genuine concern, politeness and compassion”. Therefore when migrants speak in their own
language they are obviously compromising quality care delivery since the patients who are in their care are unlikely to understand what is being talked about.

From a quality care delivery perspective, these behaviours raise some serious questions that seem to demand urgent attention from managers and other stakeholders. To help their migrant careworkers to come out of their cocoon, most managers said that they encouraged the migrant careworkers to socialise with co-workers and not to be afraid of sharing their apprehensions and fears with the managers. In this regard, Dakota, said, “I always encourage my girls to attend work meetings and social events like parties ... we also have shared lunch sometimes”. She said that she had noticed that this helped them to “loosen up”. To help the migrants to mix with other people, Christian said that,

“I consciously design my shifts in such a way that migrant workers of one nationality are not paired together.... This seems to help avoid situations where migrants working one shift keep to themselves as well as speak their own native language. I have noticed that other workers are disturbed by such behaviours”.

This was also echoed by Bailey, who said she believed that pairing a migrant worker together with a local New Zealander in her shift management seemed to help the migrant to adapt to the new culture as well as develop confidence when speaking English.

However Lindsay said that this strategy did not work for her. She said that even though she was open to that idea of pairing the migrant carer with a native New Zealander, she was limited by the realities of her overall workforce profile. She said that she did not have enough native careworkers to do this. She also said that most of the native carers were not happy to do night shifts. As a result the night shifts tended mostly to be taken by migrant carers only. In the event that a patient died during the night, one manager said that she had noticed that some of her migrant workers were not comfortable to be in that room, or to have anything to do with the corpse due to their religious beliefs. She had therefore advised her migrant carers to call her once that happened. She said that she did not force the migrants to do things that were not in agreement with their cultural beliefs: “if a death occurs, it doesn’t matter what time of the night, I have advised those who can’t deal with such issues to call me... I do not force them to do anything that is not in agreement with their culture... I have experienced this once before with one carer from Africa”
The actions of this particular manager are important in so far as they reflect her sensitivity to cultural diversity. This sensitivity of the managers seems to be in harmony with the thrust of a Strategic Human Resource Management approach that, supports the view that in order for workers to act in a manner that supports the firm to achieve competitive advantage over others, the approach to the management of the human resources of the organisation should emphasise ‘utilisation and not exploitation’ (Barney, 1991). In this way, the sensitivity of the manager towards the cultural beliefs of the worker may encourage the employee to be more sensitive to the needs of the elderly patients, in the process achieving sustainable competitive advantage over other aged care facilities.

7.8 Perceived racism and discrimination

Another set of significant challenges that the managers perceived their migrant cohort of carers experienced is perceived racism and discrimination. The managers were asked if any of their migrant cohorts of careworkers had complained of incidences of racism. Most of the managers agreed that the attitudes of some of the residents and in some cases their relatives towards migrant carers were a challenge and could easily be described as racist “depending on one’s definition of racism”. Dakota said that she believed that racism was rife at not only her facility but many others as well. She said it was important for managers not to “sweep it under the carpet and pretend it is not happening”.

A few of the other managers did not dispute the existence of racism at their facilities but they also observed that incidences of racism were not as prevalent as they were, for example, five years ago. Cody, said she had noticed that incidences of racism had toned down and she attributed this to the fact that the majority of patients were now slowly getting used to being taken care of by people from different races and colours. In this regard, another manager said that she had experienced few cases of racism at her facility. She added that she had also had the opportunity to employ migrant carers from other nursing homes who confided in her that they had decided to leave those elder care facilities because they believed that they were paid less than the native New Zealander carer for preforming the same job.

Two of the managers, Lee and Emerson, expressed the view that the question of racism could only be answered by the migrant carers themselves because “it was difficult to judge whether or not they are experiencing racism at work. Emerson said that “…. because of cultural differences, I think that things I may consider normal, may be construed as racist by other
people because of their upbringing as well...”. In the same context, Lee said that as much as they tried to protect migrants from racist attacks or behaviour, their efforts were determined by the complaints that came their way. To this end, she said that in her experience, she had noticed that migrant carers “rarely complained about racism at work”. She hastened to add that she was not “in any way saying that there is no racism here”. In the view of Lindsay, there was need for managers to create trust between migrant workers to enable them to freely express their fears without fear of victimisation. Lindsay believed that this was the greatest challenge managers had to overcome.

However, manager Dakota said that some of the migrant workers had complained about being racially abused by some of the elderly patients. In the same vein, manager Madison said that she had observed incidences of what she perceived as racism against migrant carers from the patients. She said that she had noticed that some elderly patients refused to be attended to by certain people of foreign origin. In this respect, one manager said that she was ‘ruthless’ with such cases and often adopted a hard stance by serving such family members with written warnings as a way of curtailing recurrence of racially abusive behaviour towards their workers. Another manager echoed these same views by saying that she had personally witnessed situations where relations of the elderly patients passed derogatory remarks directed at migrant workers.

All the managers seemed to agree that at different times in their management of elder care institutions, they had come across difficult relations of the elderly patients who seemed unhappy to have their family members being cared for by migrant personnel. One of the managers gave the example of one such difficult family relation:

“We also have a resident’s daughter who is so fussy about who cares for her mother ... there have been issues around some carers being too dark to care for the mother ... she sometimes says that her mother is scared of these carers yet we know it’s her problem not the mothers’. So we have given her a written warning... we are a team ... we won’t tolerate that.”

However, Bailey said that she tended to accede to the demands of the resident who was not comfortable with a carer by allocating a different carer: “I don’t think it is easy to change these people... they are at a stage in their lives where it is difficult to change their views about life, about you and me.... Some of these people grew up in environments in which
racism was not such a big issue... or if it was a big issue, very few people talked about it... its different today of course... as we see it today..”.

In her opinion, manager Madison said that: “It is difficult to control racism at work... I don’t mean just here but at many other places... this does not mean that I condone racism...but I want you to appreciate the fact that people are difficult to deal with ... and their behaviours are very difficult to control”. She said that she always made a point of resolving such cases by approaching the perpetrators once the case is brought before her. She however said that the problem was that very few of the migrants came up to her to “report these case... I believe that there are many more incidences of racial abuse than are reported to me...” In this regard, one of the facility managers said that the biggest challenge facing their attempts to ‘eliminate’ practices of racism is that “the victims rarely came to report... How do you solve a problem that has not been reported to you?” she rhetorically asked.

The majority of the managers however said that most of the racial incidents did not involve the Kiwi elderly patients but in most cases those from Germany, Russia and Australia. Another important point to note is that all the managers were aware that the sources of racist attacks were also varied and sometimes difficult to isolate. Racism was practiced by co-workers and family relations of the patients as well. All the managers revealed that they made it clear to all their carers that they would not accept any show of racial intolerance and prejudices.

Another source of perceived acts of racism by migrant careworkers turned out to be the unit managers. Some of the unit nurse managers act as the shop floor managers dealing directly with the carers most of the times. They act as operation managers in that they oversee the performance of tasks, the allocation of tasks, shift management and other day to day issues at the facility. In this respect, Christian said that she had received complaints from some migrant workers who perceived that the unit nurse manager was giving them hard tasks as well as allocating to them the most difficult patients to take care of during their shifts. She said that some of the migrant carers had complained about being allocated frail elders who could not do anything on their own. This meant that the carer’s cleaning and bathing task was more difficult than perhaps cleaning elderly patients who were able to independently perform some tasks. Christian also said that some migrant carers had complained that this same unit nurse manager was known to fiddle with the roster to reallocate ‘hard patients’ to the migrants after the original list had been drawn:
“I have a few migrant care workers who came complaining to me about a unit nurse manager who was changing the roaster without even asking them. In most cases it was when a native New Zealander carer wanted a day off or a swap... the worker complained that this unit nurse manager changed the roaster without consulting with them.”

In order to help their workers, most managers instituted strategies that were not always specifically targeted at the migrant careworkers but all the workers.

7.8.1 Aged care facilities business model: dealing effectively with racism

A significant dimension of the responses of managers regarding their inability to deal with racism is the perspective of aged care facilities as businesses that have to attract reasonable volumes of business in order to continue to survive. Managers are increasingly finding themselves at the centre as they balance the interest of their patients and those of their divergent work force. The ability to solve the conflicts arising between these two elements of the organisation is moderated by this business model perspective of aged care facilities. For example, manager Casey expressed the view that conflicts that are perceived to have racial connotations, especially between migrant carers and their patients, were ‘tricky’ in dealing with: “You have to understand that for us to be here, we must have these residents... without them we have no jobs... without the residents, we would not be sitting here discussing the issue of migrants... Meeting the needs of our new workers and our clients is not an easy task... I hope you understand my position here…”

In the same vein, Cameron said that, “It is important to remember that we can only employ some of these migrants if there are patients to take care of... I also have to think about the family relations of my patients... they have their own expectations regarding how we should look after their relatives... it’s not easy to balance these issues...” As a result she found herself ‘juggling’ a lot of seemingly irreconcilable challenges. She said that the facility relied a lot on word-of-mouth recommendations, especially those of family members, in order to attract more residents. In this regard, she said that she felt her ability to deal with racism was compromised by the pressure to keep patients and their family relations happy so that they can recommend more patients to their facility.

In the same context, manager Erin, articulated this dilemma when she said that the situation was exacerbated by the fact that it was increasingly becoming difficult to attract elderly
patients to their facility. She therefore did not want to lose the few patients that found their way into her facility by being seen as siding with workers. In order to avoid dealing with racism complaints, she had therefore made it a point to only ‘hire migrants when it is absolutely necessary’. She reckoned that without migrant workers at her facilities, there could not be any racial abuse. However when asked to comment on the sustainability of such a strategy, in light of her earlier admission that she was noticing an increased participation of migrants in the provision of aged care services, Erin said that “we are forced to make difficult choices because of things beyond our control... as managers we are also employees and have to do what we think is necessary...”

Drew echoed these very issues: “When a patient is unhappy, it is very easy to find ourselves in newspapers and TVs... my job is to make sure that this place does not generate a lot of complaints especially from our patients and their relatives... I am not saying that we are not concerned about the issues our carers bring to us... but you have to understand the bigger picture here...”

She said she had noticed that if the concerns of the family relation of their patients were not adequately addressed, most of them tended to resort to the media to air their grievances: “I am sure you have come across so many stories saying this and that about rest homes... such publicity is not good for us”. Reconciling the needs of the patients, who in some cases racially abused the carers, and those of the carees proved a challenge.

In the same context, Cody and Emerson said that the nature of the facility determined to large extent how the manager could deal with racism. She gave the example of a colleague of hers who was managing an aged care institution where the patients owned the flats they were staying in. From a business viewpoint, the conflict arising due to perceived racism in such an aged care facility where the patients wielded a lot power, because he or she owned the flat tended to result in the carer’s concerns receiving little attention. The manager said that it was important to be ‘pragmatic’ when dealing with employee-patient relationships and said that sometimes the only advice she could give in the face of persistent racism was to suggest the employee find alternative places of work.

Some managers said that they warned their new migrant careworkers that if they came across any form of racism they should not take notice of it, “they should just ignore it”. They are to be “patient” and show a lot of “perseverance” as it was difficult to change the way different
racial groups regarded each other. She also said that “... sometimes you get to a conclusion that the interest of the employee are better served if the employee seeks alternative employment.... This is not to say I support bad treatment of the employees... sometimes you realise that you are dealing with issues that are way beyond your control...”

Another manager however said that in some cases racism was practiced by her elderly patients suffering from dementia or some form of mental instability. In this case, the manager had advised the carers to ignore their racial taunts because of their mental instabilities. The managers however did not condone any form of racism, and the advice they were giving to the workers was a result of realising that there were other issues beyond their control or influence and that made it difficult for them to deal effectively with perceived racism.

Cameron, said that she had settled on a strategy which she thought went a long way in diffusing tensions between her elderly patients and the service providers. She said that her strategy involved making sure that as soon as the migrant carer joined her team, she took them around the facility introducing them to the patients and all other people at the facility. She realised that this gave them time to talk and also the opportunity to know each other. Cameron said that she had noticed that the elderly patients were happy to be accorded a chance to meet with the new carer outside the busy work routine.

Another manager had been proactive in dealing with racism by avoiding the employment of any person belonging to a certain named ethnic group because she had noticed over time that there was tension between some of her patients and carers of this ethnic group. She had discovered that some of the elderly patients did not take kindly for example to being taken care of, by some carers of a certain country of origin. In the past some of these patients had been soldiers and fought in wars against the countries to which these foreign workers belonged to, for example during World War II or some other international war. The elderly clients complained that such carers made them relive the horror of war that they experienced. A worker who resembled this ethnic group that triggered horrific flashbacks of war occurrences, was therefore reassigned to more accommodating patients. The manager was however not able to judge the nature of psychological damage that could have been caused to the innocent migrant worker who was being persecuted for belonging to a racial group or country that the elderly patient had fought against in the past, when she had not even been born.
An issue of concern from the perspective of this study is the possible reaction of the migrant carer who perceived racism and the subsequent impact of those reactions to quality care delivery. Most of the managers said that it was difficult to monitor the reaction of the migrant carer who was perceiving racism at the work place. Drew said that carers were in most cases alone with the patient and it was difficult for them to always notice any vengeful behaviour pattern from migrants to patients who the migrants perceived as racially abusing them. Christian however said that she had received complaints from some of her patients who had been accused of racism by their migrant carers. This is evidence of the existence of tension between a carer and a caree. From a quality care viewpoint, such tension has far reaching implications. The fact that a patient complained of being accused of racism, rightly or wrongly, is an event that is not consistent with conditions that support quality care delivery especially as it is defined by most patients.
7.8.2 Racism and management interventions: some wider implications

The views of managers make for some interesting reading and reflect in many ways the lack of a concerted approach to tackling racism at their workplaces. Admittedly, the responses show the complex nature of racism and the difficulties associated with dealing with it. Extant studies report that persistent manager disapproval and attitudes towards the work effort of migrants, have emerged as a key reason why migrants feel they are discriminated against. For example, it is well established that most migrant workers have experienced discrimination due to the fact that they lack New Zealand work experience and have low levels of English language skills. These experiences have become a leading cause for complaints to the Race Relations Office (East & Bays Courier, 2007).

These findings make interesting reading especially when considered from the viewpoint of racisms and discrimination. For example, the literature covered already indicated that racism and discrimination from employers is reflected in conditions of service, managers’ approach to allocating work tasks, as well the managers’ attitudes and actions regarding progression opportunities for migrant workers (Cangiano et al., 2009; McGregor, 2007).

However, the inadequacies of the managers’ responses to dealing effectively with racism at work are understandable especially when one considers the complex nature of discrimination and racism. For example the literature has already argued that in many cases language and skin colour are used as markers to classify, and negatively evaluate, others’ cultures (Johnstone and Kanitsaki, 2008) leading to discrimination and racism (Stevens, Hussein, & Manthorpe, 2012). There is also evidence elsewhere that perceptions of what constitutes racism and discrimination vary from one culture to another (Stevens, Hussein, & Manthorpe, 2012).

The managers’ responses are also interesting when considered from a strategic HRM perspective, as well as the fact that care delivery is simultaneously produced and consumed. It can be argued that the efforts of most managers, although not misplaced, are based on a clearly challenged perspective of what constitutes organisations and the successful delivery of quality care services. Care is a service that relies on the interaction between the provider and the receiver. It does not seem to make a lot of sense to allow the business interests of a firm, such as attracting more volumes, (in this case more elderly patients), to take precedence over those of the very people who provide these services. A strategic approach to HR and the
achievement of sustainable competitive advantage implies that the human resources are the avenue through which the interests of the business can be maintained in a healthy form (Barney, 1991; Pfeiffer, 1994; 1995). It seems therefore naïve to treat the interests of any of these two organisational elements (patients and employees) as having precedence over the other. The two are inseparable. It is well established that employees establish a significant source of competitive advantage for firms (Barney, 1991; Pfeiffer, 1994). Carer interests should therefore not pay second fiddle to those of their patients.

7.9 Chapter summary

The chapter has presented findings from the field research regarding the managers’ perceptions about the implications of the increased participation of migrants as carers. The findings reflect managers as sharing the views of studies conducted elsewhere, to the effect that migrants are becoming integral in the provision of care to the elderly patients. The managers also echo findings of other studies, that most of the native active job seekers do not view caregiving as an attractive career, which continues to pave way for more migrants to be employed as carers. The chapter has also presented findings that show that most of the managers believe that their migrant carers perceive racism and discrimination, among other challenges at work. The managers also seem to agree that these challenges the migrants face have an impact on the quality of care. Some of the managers have made attempts to resolve the issues the managers face although, their approaches do not seem robust enough to deal with these challenges. In this context, the following final chapter provides a concluding discussion to the whole study focusing on the implications of the managers’ responses to the migrants’ challenges, in relation to the goal of aged care centres providing quality care to their aged patients. Finally, the chapter presents some recommendations to improve quality care delivery in the aged care sector in the context of the increased role migrants play in the provision of care.
Chapter 8: Concluding discussion

The main aim of this study was to develop a better understanding of the challenges associated with the employment of migrant workers in the elderly care sector. Subsequent to this, the study investigated the strategies employed in the management of migrant care workers to enhance service delivery. In this regard, the study attempted to address a gap in the understanding of the important issues arising from the employment of migrant care workers in the aged care sector. To this end, this study provides a basis to assess whether or not managers perceive migrant carers as a special group that requires specialised management attention so that the quality of service they provide to the aged is not compromised.

In this regard, the study has provided evidence showing that the Western world’s population is ageing, with repercussions on the demand for long-term care services as well as the ability of the aged care sector to continue to provide quality care to the elderly patients. The indigenous workforce needed to care for the aged is becoming less and most of the Western industrialised countries are increasingly relying on migrants to provide care to the elderly. This trend does not show any sign of abating and therefore calls upon all stakeholders to share ideas on how to manage this new group of careworkers in order to avoid compromising quality elder-care delivery.

This study’s findings reflect the majority of the managers’ view that migrants are increasingly becoming an important player in the delivery of care. They also perceive the participation of migrants as having largely improved quality care delivery in the aged care sector. In this respect, these managers’ observations echo findings of studies conducted elsewhere by various authors such as Cangiano et al., (2009) and Walsh and O’Shea, (2009).

In the context of Dunedin, there is also strong evidence that the number of people needing aged care is also on the rise. In the same vein, another reality is that migrant carers will continue to play a significant role in the provision of care. The University of Otago and Otago Polytechnic will continue to attract foreign students who, as trends show, tend to seek care-jobs to supplement their student allowances. In addition partners of internation students and those of other professional immigrants working in other sectors of the economy, in most cases work as carers. The migrants are therefore going to be a significant component of the aged care workforce. The managers’ relationships and understanding of this group are therefore integral to efforts directed at delivering quality care to aged care patients.
Whilst appreciating that the employment of migrant carers come with their own challenges, such as the visa and immigration issues among others, the managers acknowledged that these are easily offset by the positives, such as a positive work ethic, flexibility and commitment to high performance delivery that the migrant pool of workers generally bring to the workplace.

The participation of migrants as carers however needs to be placed within the larger context of changes that are taking place in the aged care industry. Currently, most aged care programmes are funded by government and supplemented by user co-payments. The taxpayers therefore bear a large part of the cost of providing aged care services. In the context of an ageing population and an increasing dependency ratio, this implies that there is likely to be a continued decrease in the number of workers, which will mean that a small number of taxpayers will be asked to sustain the aged care industry needs. Competition for funding therefore is likely to intensify and facilities that will continue to attract government funding will have to be seen to be doing things right. In the same vein, the growth of the senior citizens market has attracted many private sector aged-care providers to join the industry. The aged care industry has therefore largely been commercialised, implying that the ‘welfare’ approach to aged care provision has had to give way to more commercial management approaches.

As a result of the increased commercialization of the aged care market, both the ‘Not For Profit’ or ‘For Profit,’ aged care facilities are increasingly looking for sources of competitive advantage, just like any other commercial profit driven organisations operating in an open market. Since elder care facilities operate like any other business, they must be aware of the significant role ‘good consistent service’ plays in encouraging customers not to consider switching care facilities in search of those that have a reputation of providing consistently, high levels of care. The delivery of quality or superior aged care services has therefore become pivotal to the aged care facilities’ desire to remain competitive in the market place. This means that managers can no longer afford to view aged patients as just customers, but as clients that pay to receive certain acceptable levels of services. The continued success of aged care facilities in attracting more residents therefore depends largely on how their services approximate to the demands of their clients; the aged patients, and their family relations.

This study has cited research that suggest aged care patients value more the quality of interactions they have with their carers over the technical aspects of aged care. Compassion, honesty, genuine concern, attitude, tone of voice are highly valued by aged carers. Good
service in a care environment needs also to be a considered from the viewpoint of care as a service exhibiting characteristics like intangibility and simultaneous of production and consumption, all which present challenges for carers in their attempt to consistently provide compassionate, caring and thoughtful care to the elderly patients. The inseparability dimension of services makes service providers and their customers dependent on one another for the success of service outcomes (Bates, Bates, & Johnston, 2003; Lawler, 2001). The literature on service management also suggests that services must largely be viewed from the customers’ perspectives since customers are the ones that determine the quality of the service they experience (Edvardsson, 1998).

It is in this context that the study considers the human resources of aged care facilities as the primary source of competitive advantage, especially when it is considered that the dimensions that the elderly use to judge quality care are largely based on the quality of interactions that occur between them and their carers. Service delivery is characterised by intense social exchanges between service employees and customers (Parasuraman et al., 1985; Sierra & McQuitty, 2005) that create a sense of shared responsibility for the nature of outcomes from these service encounters. Acknowledging the ‘mutual interdependence of care relationships’ (Lyon, 2006) is therefore fundamental to the recognition of the important role migrant carers play in aged care provision.

In light of the increased participation of migrants as carers, this implies that management has to focus on making sure the migrant carers’ conceptualisation of care and its delivery as well as what constitutes ‘quality care’, are not at a tangent with the beliefs, desires and care conceptualisations of the care receivers. Migrants however bring with them their own cultural perspectives of quality care and the manner in which it can be delivered. In some cases their views may not be in harmony with the perspectives of those who receive care. It is in this regard, that the role of managers becomes significant to make sure that the aged care environment, as well the service encounters, are managed in a fashion that promotes harmony between carees and carers, especially regarding what constitutes quality care. By their own admission, the managers are aware that they have to play an important role in equipping the migrant carers, who are increasingly becoming care providers, with the necessary technical and behavioural skills that can make their facility competitively different from the next one.

‘Care’ is produced and consumed at the same time and its quality is determined to a large extent, by the nature of interactions between the care provider and the care receiver. Because
of the human aspect of the caring relationships, the HRM of migrant workers is therefore an important aspect of developing and maintaining competitive advantage.

In this regard, one of the fundamental issues that managers who deal with migrant carers have to address, relates to the identification and amelioration of the restrictive factors that may impede quality care delivery by migrant carers. To this end the managers identified diverse challenges such as visa processing, perceived racism, perceived discrimination, poor English language proficiency skills, and culture shocks, as some significant issues that could disrupt quality care delivery by migrants. The managers can be commended for example, for making attempts to help the migrants with the processing of their visa and work permits, suggesting that they are aware of the integral role that migrants are playing in delivery of care, especially since caregiving is increasingly becoming unpopular with most indigenous workers. However, the managers cannot do much to help their migrant carers with their visa applications since the policy stipulations do not consider caregiving as requiring dedicated strategies to attract migrants to fill up the vacancies. Their views are in harmony with extant studies’ views that the employment of migrants as carers in most countries has not received dedicated attention from the responsible policy makers (MacGregor, 2007; Walsh and O’Shea, 2009). This has therefore, in some cases, made the process of employing migrant carers a nightmare.

However, the effectiveness of responses of the managers to some of these factors impeding or possessing the potential to impede, the migrants’ ability to deliver care are largely questionable, although in some cases commendable. For example whilst the managers were aware that the accents and lack of English proficiency skills of some of their migrant carers were in some cases interfering with attempts to deliver quality care, none of the managers had a comprehensive language training programme to ameliorate this problem. In the same vein, although the managers’ levels of understanding of the perceived racial and discrimination challenges that their migrant cohort of careworker faces at the work are fairly high, their approaches to cases of perceived racism and discrimination are questionable. In addition, the managers’ attempts to encourage migrants and other diverse culture groups to integrate do not seem adequate enough to help migrants to integrate into the new work environment.

The dimensions that the elderly patients use to judge quality care can easily be ignored by the carer that, for example, is told to show ‘perseverance’ or ‘ignore’ what they perceive as racist attacks, on the bases that they are committed by ‘demented’ ‘frail’ or ‘old’ patients.
The carer could easily perceive that the manager is condoning these racial attacks, even though most of the managers categorically said that they do not condone racism. The carer might decide to take the law into their own hands and mete out their own brand of retributive justice, with serious implications for the welfare of patients. An example of this is the case in which a manager walked into a room in which the migrant carer was speaking in a ‘rude tone’ to the patient. It can also be argued that some migrant workers’ decision to keep to themselves and not complain about perceived racism and discrimination is linked to the attitude of some managers who said that they did not consider the migrants as unique and therefore treated them like any other worker.

The significance of dealing effectively with the challenges that carers encounter can also be considered from the viewpoint of the concept of productivity. The ILO defines productivity as,

“a relationship between outputs and inputs. It arises when an increase in output occurs with a less than proportionate increase in inputs, or when the same output is produced with fewer inputs” (2005, 5).

When the worker perceives that managers are not taking their complaints about racism seriously their reaction, such as ‘speaking in a rude tone’ to patients, is a reflection of reduction in the inputs by the carer, which ultimately affects the quality of outputs, in this case, the happiness and general wellbeing of the elderly patient.

It can therefore be argued that advising migrant carers to endure racist attacks or to seek employment elsewhere reflects a stymied appreciation of how employees can impact on productivity. The literature on how stressed individuals sometimes cope with stress highlights that workers can disengage or try to spend as little time as possible in an environment that they perceive as causing stress to them (Chang et al., 2006; Cox and Blake, 1991; Folkman and Lazarus, 1991). Some of these stress coping strategies are clearly not in harmony with behaviour patterns that are consistent with the delivery of quality care. Speaking in a rude tone to patients may therefore be a stress coping strategy. Considering the variables of compassion, politeness, and genuine concern that elder patients use to define quality care, a disengagement or confrontational stress coping strategy adopted by a migrant carer will go a long way in disrupting quality care delivery. It is important therefore to note that the
productivity of careworkers, just as is the case with other professions, is linked to the inputs or support mechanisms of their managers.

Findings however do not reflect managers as giving these issues the gravitas that they deserve although it is commendable that one of the managers took the radical step of challenging family relations of patients that behaved uncouthly to her migrant workers. It can therefore be argued that one of the most negative indictments against the managers’ handling of migrant issues and concerns emanates from the managers’ clearly challenged understanding of the intercultural nature of the service relationships and the implications on overall quality of care.

Therefore, in the context of the unique challenges that migrants encounter as individuals operating in a new society and performing jobs that, ordinarily in their home environments most of them would not do, it can be argued that the HRM role of care facility managers needs to be revisited. Although there is evidence of the managers’ appreciation of this disadvantaged position of migrant careworkers, there is still a glaring lack of dedicated strategies on the part of managers to deal with, for example, training and professional development needs of migrant careworkers.

The migrant carers therefore need a lot of assistance in order to adapt to the new work tasks. This issue is of great concern in light of earlier discussions to the effect that most migrants, who end up as carers, possess high qualifications in other sectors of the economy but fail to secure jobs that are in line with those qualifications. It was also reported earlier on that some managers noticed that during the orientation process, most of the migrants appeared shocked as they learnt about the ‘nitty-gritties’ of taking care of the elderly. The managers also noticed that most migrants tended to keep to themselves and conversed in their native language with serious repercussions for the quality of interactions they established with the elderly patients and co-carers. The findings of the study indicated that in some cases there have also been conflicts between migrant carers and co-native carers. The migrant carers’ perception of unfair allocation of duties, and that native carers are allocated ‘good shifts’ in relation to migrants, among other perceived acts of discrimination and racism, call into question the cultural competence skill levels of some of the managers.

The migrants’ challenges as perceived by managers suggest that the work place must become a focal point of more comprehensive attempts to acculturate the migrants, especially as most of them find themselves doing a job that they ordinarily would not do in their own country of
origin. In this context, the managers’ observation that the low English communication skills of most of the migrants had made it difficult for the managers to judge whether or not the migrants needed further training, is significant especially when considered from a training-needs analysis perspective. It could be argued that this observation of the existence of this confusion amongst most of the new migrant recruits, should have urged the managers to craft an extended orientation, induction and training programme specifically for the migrants. However, only one facility had an orientation programme that extended over three months, which in some way reflects that the intercultural context in which care is provided in these facilities is not receiving due attention and consideration from most of the managers.

Literature on induction and orientation (Atkins & Gilbert, 2003) suggests that these are strategic processes that can present managers with an opportunity to help their new recruits to adjust to the way things are done in their new environment. However findings show that the managers largely apply generic training, induction and orientation programmes to all new employees: migrants or native. Whilst the managers can be lauded for showing admirable commitment to equal treatment of all workers, they may also be criticised for refusing to accept that migrants who are becoming dominant in the employment of most aged care homes are unique and may need to be attended to in a unique way.

The managers’ responses to the raft of challenges migrant cares encounter support the conclusion that managers need some form of diversity training, among other skills, in order to develop cultural competence skills that are necessary in dealing with a migrant workforce. Migrants need to be aided to culturally adapt to the new culture of caregiving which may be alien to most of them. The migrants tend to experience cultural shock in their different points of interaction with different layers of New Zealand. The work area is one such area that presents a huge shock, not necessarily because of the new environment but more importantly because of the nature of carework job. Some aspects of cultural shock are strain, anxiety, feelings of loss, tension, frustration, confusion, and the general inability to deal with the new environment due to unfamiliarity with cognitive aspects and role playing skills (Winkelman, 1994). The managers need the skills to go about helping these migrants.
8.1 Managers’ role in the migrant carers’ cross-cultural adaption

The study has shown that most migrant carers encounter challenges associated with understanding the culture of caregiving. The transition period immediately after joining a health facility as a carer can be critical in their successful integration, depending on the innovativeness of management practices in place to induct and orientate new migrant recruits. The literature on cross-cultural adaptation suggests that organisational level characteristics can help the migrant to adjust and fit into the new environment. It is however, important to note that the support mechanisms that take place at the workplace should be part and parcel of more comprehensive societal, community or country wide support mechanisms that may be needed to help internationals to adjust.

Various studies suggest that there are many factors that should be considered in exploring how internationals adjust to a new cultural environment. This is however not to suggest that all migrants will react in the same manner when they relocate to a new environment.

The following Figure 8.1 makes an attempt to deconstruct the major factors that have to be considered in cross-cultural adjustment. Although some of the variables may not be entirely relevant to careworkers, the diagram highlights some important issues that have been raised in Chapters 1, 2, 3 and 4 about previous experiences of migrants, as integral to the understanding of the strategies to be put in place, to help migrants to adjust to the new environment. The diagram also captures the important factors such as organisational culture, training and its integral role in helping new recruits to adapt to new job tasks and job environments. Black et al., (1991) model of expatriate adjustment identifies various factors that affect adjustment. The most important of these are job-related and organizational factors. The model also divided determinants into factors related to “anticipatory adjustment”, that is adjustment in the period before departure, and factors related to “in-country adjustment”, that is the adjustment to the host country.

Although the model has been criticised for lacking empirical grounding, in its simplicity it reinforces the suggestion that that managers can play an important role in helping new workers fit into a new work environment. The managers play an important role in shaping the organisational cultural aspects, such as compensation and benefits, promotion opportunities, mentor assignment, work assignment, role clarity, job challenge, training and professional development of employees (Parker & McEvoy, 1993). In this regard, most literature suggest
that there is a generally positive relationship between adjustment and job performance (Puck, Holtbrügge and Dölling, (2003, 18).

**Figure 8.1: Understanding International Adjustment**

Source: Black et al., (1991, 24)
The field of diversity management provides some interesting insights as well. It is argued that diversity management emphasizes the valuing and taking advantage of individual differences or cultural pluralism to facilitate the maximization of people’s potential (Lawler, 2001). Effective diversity management can lead to the creation of teams that can achieve greater innovation and creativity, and outperform homogenous teams (Cox & Blake, 1991). Effective diversity management encourages a culture of inclusion that creates a nurturing work environment, teamwork, participation and cohesiveness (Dwyer, Richard & Chadwick, 2003).

There is evidence that if diversity is not adequately managed, it can lead to cross-cultural conflict (Church 1995; Cox & Blake, 1991; Francesco & Gold 2005).

Lynch and Hanson (2004) argue that the development of cultural awareness, including self-awareness about one’s own culture, and associated values and assumptions on behaviour and interactions, is the first step towards developing cultural competence. The managers need to develop an awareness of their own values and the stereotypes they hold against themselves and other races. This is especially important when considered from the perspective of elder quality care it is dependent largely on the inseparable observable behavioral actions and reactions of the carer and caree that characterize the care service encounter interactions.

Cultural competence comprises the worker’s attitudes, knowledge and skills, and requires an acceptance that long-term, on-going and persistent development is necessary (Minnesota Department of Human Services, 2004). In this context, three elements are generally identified as key to the development of cultural competence. These are:

- developing cultural awareness, including self-awareness about one’s own culture
- acquiring knowledge about other cultures
- developing cross-cultural skills (Lynch and Hanson, 2004).

The significance of diversity training and development of cultural competence skills to the continued survival of these aged care facilities cannot be overstated. Earlier on, the study described aged care facilities as operating along the same lines as other profit driven organisations. The argument made was that in order for the facilities to continue to attract large volumes of aged patients, they have to adapt a ‘resource view of the firm’ (Barney, 1995; Becker & Gerhart, 1996) in which their sustainable competitive advantage is driven by
the unique manner in which their human resources behave in the care service encounters. The human resources are the source of sustainable difference for aged care institutions that intend to stay ahead of other competitors in the same aged care sector.

The case for management of cultural diversity has various advantages such as cost minimisation, efficiency in allocating resources, engendering a spirit of creativity and innovation within the organisation, as well as making the organisation more flexible to adapt to the changing realities of the business environment (Cox and Blake, 1991). These issues are captured in Figure 8.2.

| 1. Cost Argument                           | As organisations become more diverse, the cost of a poor job in integration workers will increase. Those who handle this well, will thus create cost advantages over those who don’t. |
| 2. Resource-Acquisition Argument          | Companies develop reputations on favorability as prospective employers for women and ethnic minorities. Those with the best reputations for managing diversity will win the competition for the best personnel. As the labor pool shrinks and changes composition, this edge will become increasingly important. |
| 3. Markering Argument                     | For multi-national organisations, the insight and cultural sensitivity that members with roots in other countries bring to the marketing effort should improve these efforts in important ways. The same rationale applies to marketing to subpopulations within domestic operations. |
| 4. Creativity Argument                    | Diversity of perspectives and less emphasis on conformity to norms of the past (which characterise the modern approach to management of diversity) should improve the level of creativity. |
| 5. Problem-solving argument               | Heterogeneity in decision and problem solving groups potentially produces better decisions through a wider range of perspectives and more thorough critical analysis of issues. |
| 6. System Flexibility Argument            | An implication of the multicultural model for managing diversity is that the system will become less determinant, less standardised, and therefore more fluid. The increased fluidity should create greater flexibility to react to environmental changes (i.e reactions should be faster and less cost). |

Figure 8.2: Managing cultural diversity for competitive advantage

Source: Adapted from Cox and Blake, (1991, 47)
These advantages are all very significant especially when considered from the viewpoint of strategies that some of the managers used to solve complaints, that their carers brought forward regarding being racially abused by patients who, in this case owned the facilities they were living in. Some of the managers advised aggrieved migrant workers to seek alternative employment or look for a job elsewhere because they could not afford to fight the ‘goose that was laying the golden egg’. Their reasoning was that the patients’ interests were more important than those of the carer. This purely economic rationalisation seems faulty and unsustainable. The ability of some of the managers to deal effectively with the few cases of perceived racism and discrimination was therefore compromised by pressures to deal with trying to balance diverse interests: the business interests of the owners of rest homes, the interests of patients, and those of carers.

Although there is a clear failure on the part of some of these managers to appreciate that these interests are inseparable, still the managers’ position is understandable when they in some cases treat the concerns of their patients or family relations of patients as more important than those of a single carer. Pragmatically, aged care facilities compete for aged patients. The same can’t be said for carers. The business model of aged care facilities seem to require that managers develop a new set of skills capable of handling the changing competitive aged care industry business environment.

The resource view of the firm, which is also in line with the strategic ‘soft’ HRM dimension of human resource management, that this study has used to frame the exploration of these, takes the position that sustainable competitive advantage is more likely achievable when the organisation acknowledges the indispensable role of the people providing care. In this respect, this study’s conceptualisation of care as largely intangible and dependent largely on the nature of interactions between the carer, caree, managers and family relations of carees, reinforces the idea that sustainable competitive advantage in the aged care sector is more likely to be achieved when management pays more attention to the intercultural dimension of their service encounter interactions. In this regard, the role of diversity training to equip managers with the necessary cultural competences cannot be overstated.
8.2 Recommendations

A number of recommendations can be suggested in light of the views of these managers about their perceptions of the challenges that migrant carers experience vis-à-vis the delivery of aged quality care.

8.2.1 Recommendations to government and policy makers

8.2.1.1 Visa or work permits for migrant carers

Since the government is responsible for monitoring and regulation of care services, it can therefore influence labour supply through adopting innovative approaches to its immigration policy. The study’s findings indicate that most managers perceive that the Immigration Department and the policies that govern the employment of migrants, have not always responded well to the labour shortages they face in the sector. Most of the managers, as recorded earlier, suggested that the Immigration Department should consider the special nature of carework and be more positive when dealing with applicants for visas. The government should seriously reconsider its attitude towards the care sector especially in light of the managers’ comments to the effect that native unemployed people are not interested in doing care jobs. The elderly patients require care and those that are offering it now need support with their visa applications.

8.2.1.2 Aged care needs more support: resource allocation

All the managers perceived that pay rates for ‘ordinary’ careworkers were abysmal. This situation affects all carers regardless of nationality or origin. However, as discussed earlier on, this factor assumes greater significance when considered from the perspective that most of the migrants who are taking up this job are highly qualified individuals, albeit in other sectors. The study recommends that the responsible authorities support this industry by raising the wage rates, as well as providing the workers with machines that can make the job of lifting aged patients much lighter.

8.2.1.3 Language and communication training

Current research has already documented that elderly care patients give more prominence to the soft intangible dimensions of quality care than technical expertise, such as medical knowledge and operation of machines such as hoists. Compassion, patience and ability to
create relationships defined how the elderly preferred to be treated. Communication skills seem intertwined with the ability to show compassion, politeness and other variables that the elderly patients use to judge quality care. The development, cultivation and transference of the necessary communication skills to the migrants seems to demand that employers and policy makers should work together to support the language and cultural training of migrant workers, to enable them to do their duties more effectively.

8.2.1.4 Support the skills and career development of migrant care workers

In light of the problem of underemployment that seems to characterise the profile of most migrant carers, it is suggested that the employers, Ministry of Health and government should also consider how to develop and support the professional growth of such people. The ACE and Career Force qualifications, which the managers recommend to their migrants carers and every carer, do not seem to come close to addressing the professional development needs of such people. It is important for all concerned stakeholders to understand the value of people in the firm and their role in competitive advantage. People play an important role in the delivery of this intangible output in the form of a happy caree, which in turn will drive more business into the firm.

8.2.2 Recommendations to managers of aged care facilities

8.2.2.1 Offer more social support to migrants

The observation by most of the managers that many of the migrants tended to keep to themselves seems to be showcasing the dire need for various forms of support for migrants so that they can come out of their ‘cocoon’. Opportunities for informal conversation need to be created or intensified such as sharing lunch and break time with them to encourage migrant carers to freely express themselves. The managers should therefore consider the social integration of the migrants as well as their development of social care skills as an integral part of their job. The managers should not leave migrant carers to ‘plod on their own in darkness’, as this might affect how they interact with the customers. Managers who do not tolerate prejudice in the workplace are more likely to have a significant, uplifting effect on worker morale and sense of job satisfaction, than those who do not.

8.2.2.2 The need for stronger regulations governing worker discrimination and racism

The managers’ perceptions of the challenges migrants face as carers suggest that there is a
need for the government of New Zealand to introduce stronger regulations that deal with racism and discrimination. In light of these views of managers, there seems to be a justification for a call to ensure that policies and practices of equal opportunity are developed so that the rights and welfare of migrant workers as well their indigenous co-workers are safeguarded. It could also be argued that perhaps the affected aged care provider institutions need to strengthen their monitoring role to make sure that migrants feel that the management does not condone racism or discrimination in whatever form it may appear.

8.2.2.3 Diversity management training

In light of the challenges that managers perceive migrants carers experience in their day to day discharge of caregiving duties, it seems reasonable to suggest that aged care institutions take diversity management training more seriously. This may develop cultural competences to enhance their ability to devise the necessary strategies that support excellence in quality care delivery in a multicultural elder care delivery environment.

8.2.2.4 Need for increased support for migrants to fit into the new work environment

The managers’ responses to the challenges that are faced by many of the migrant carers leave a lot to be desired. In light of their admission that migrants were increasingly playing a significant role in the delivery of care, it seems justified that the institutions come up with some robust innovative support strategies to help the migrant carers to adjust well into the new job tasks. Judging by the responses of the managers, some of the migrants need training in social care skills and language proficiency, among other training-needs areas. The training-needs-analysis arm of the management function of aged care facilities must diligently identify the challenges that migrants deal with, especially those that can be rectified through training.

8.3 Recommendations for further research

This study has largely focused on exploring the managers’ perceptions of the challenges migrant carers face in the context of the theme of quality care delivery to the elderly patients. The rationale behind this approach is that the managers’ conceptualisation and perceptions of the challenges that the migrant carers face are more likely to determine the nature of corrective actions that they will take, or not take. The perceptions of the managers, among other factors, regarding the severity of the migrant carer problems are the managers’ reality, and they will form the basis of their actions or reactions towards these challenges.
Admittedly, this study’s approach has its limitations because it only presents views of managers about what affects the migrants without asking the migrants themselves. In light of this view, this study recommends that further studies be conducted to record the perspectives of migrant carers. This study has already provided a platform from which the actual perspectives of migrant carers will be considered and perhaps evaluate whether the managers have a comprehensive understanding of the depth and range of the challenges migrant carers face vis-à-vis, quality care delivery. The study also recommends that other studies incorporate more facilities across the country in order to provide a more comprehensive view of the managers, regarding their understanding of the challenges migrant carers face and the impact of these challenges present to the ability of the migrant carers to deliver quality care delivery.

8.4 Conclusion

Population ageing in New Zealand in general and in Dunedin in particular, resulting from the decline in fertility rates and an increase in longevity through advances in medical technology and public health improvements among other factors, will continue to put pressure on the demand for aged care services. Evidence however, shows that the native workforce do not consider aged care jobs attractive enough thereby putting into question the ability of the aged care industry to continue to provide quality care to the elderly patients. The increased and continued reliance on migrants to provide care to the aged therefore will continue to be a component of how New Zealand takes care of its ageing population. Although the migrant carers’ population may be small in Dunedin, it is predicted that it will only get larger. Due to the increased commercialisation of the aged care industry, care providers have found themselves devising ways in which they can continue to attract more business in order to survive. The quality of care provided has emerged as the basis of aged care facilities’ competitive strength. In this regard the HRM of migrant workers will continue to be an important aspect of developing and maintaining competitive advantage, especially since quality care is defined by the quality of interactions that take place between carees and carers. The management of care service encounters is therefore going to determine whether or not care facilities will continue to attract adequate volumes of business necessary for the survival of the facilities. The managers’ perceptions of the issues and challenges that may impede the ability of migrants to deliver care, and the subsequent steps managers will take to ameliorate these challenges, are therefore crucial to the quality of care and life outcomes.
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Appendix 1: Extended Interview Schedule

Aged Care Institutions Management: A study of management’s engagement strategies to support migrant careworkers’ delivery of quality elderly care

Thank you for giving me this opportunity to interview you about various issues to do with the aged care sector in general and your facility in particular.

To start our conversation,

1. May be you can start by sharing with me your observations about the nature of the aged care sector, more specifically the growth patterns
2. What about your experiences regarding employment issues in the aged care sector in general and here in particular [labour supply]
3. Also share with me any important issues regarding the composition of your employees [nationality, gender]
4. How would you explain the trends in the employment migrants as carers?
5. What characteristics define the migrants that you have come into contact with? [their social background, educational levels, suitability for the job]
6. What is your understanding of the aspirations and attitudes of your migrant carers toward their vocational and educational futures?
7. How would you describe the impact of migrants to the delivery of care here?
8. In your view what constitutes quality elder care?
9. What impact has the participation of migrants had on the achievement of these very dimensions you have identified in your definition of quality care?
10. What specific characteristics of migrants have either enhanced or compromised quality care delivery?
11. What is your view of the attitudes of the migrants towards the care job?
12. How would you describe the reactions of your patients to being attended to by migrant carers: any conflicts at all?
13. How best do you think the conflicts, if any, can be dealt with?: [perceived racism, perceived discrimination]
14. How do they migrant employees perceive your role in conflict resolution? (partial or not?)
15. Why do you think they perceive your role in that way?
16. What is your understanding of the migrant carers’ perception of employment practices here: allocation of shifts, pay, training, promotion
17. What strategies have you put in place to help the migrants to quickly get used to the work environment?
18. How would you describe government policies and regulations which govern the employment of migrants? [enabler or hindrance]
19. What do you consider as the most important management issues that a manager in your position should concern themselves with in order to have an attractive facility?
20. What do you think are some critical management skills that a manager of a facility that employees people of different cultures should have?
21. Share with me the challenges, if any, that you encounter when recruiting migrant carers?
22. Share with me what you consider to the biggest challenges of employing migrant carers.
23. Share with me what you consider to be the most attractive qualities of migrant carers
24. Are there any other comments that you would like to make that might help to inform this research project?

Thank you.
Appendix 2: Invitation Letter to Interviewees

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School of Business
P.O Box 56
Dunedin 9054
New Zealand

Esther Chaderopa
Office Phone: (03) 479 8410
Email Address esther.ngocha-chaderopa@otago.ac.nz

Date
Participant’s name
Address of Facility

Dear ………………………………………………………………………………………………

I am currently involved in a research project on migrant care workers and quality of care. Specifically, I would appreciate a brief meeting with you to discuss in person the following issues:

What aspects of human resource management practice do you see are important when supporting migrant care workers with the delivery of quality care in your organisation? How do external factors impact on the delivery of quality care by the migrant employees within your organisation?
I have enclosed an information sheet setting out the key concerns of my project. I will phone on the …. of October and hope to be able to set a time to meet with you. I look forward to talking to you.

Yours sincerely

Esther Chaderopa