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Negotiating User Preferences, Discrimination, and Demand for Migrant Labour in Long-Term Care

Abstract

The restructuring of long-term care for older people has been marked both by the role of the market and by the role of migrant labor. This article develops the analysis of these processes at the microlevel of the provision of care. It draws on data collected as part of a cross-national comparative study on the employment of migrant care workers in residential care homes and home care services for older people in England and Ireland. The article examines, first, the ways in which divisions of race, ethnicity, and citizenship shape the preferences of service providers/employers and some service users as regards who provides care. Second, it examines how the institutional context of quasi-markets in long-term care shapes the negotiation of demand for migrant labor, the racialized preferences of individual users, alongside the rights of care workers to non-discrimination. It is argued that market-oriented policies for personalization, as well as for cost containment, raise implications for divisions of race, ethnicity, and citizenship in the provision of long-term care. At the same time, those divisions

point to the limits of framing care in terms of the preferences of the individual as opposed to the social relations in which care is embedded.

Introduction

The employment of migrant workers in the provision of care for older people is evident across western welfare states. However, the role of migrant labor is located in varying institutional contexts in terms of the organization of care. In Southern European countries, such as Italy and Spain, where the public provision of care services for older people is more limited, migrant workers have been employed in the household to supplement the unpaid care of the family (Bettio et al. 2006; León 2010). In contrast, in countries such as the UK and Ireland, where the provision of long-term care services is more developed, albeit with significant variation and shortfalls in provision, migrant workers have been increasingly recruited in the context of market reforms to public provision. Those changes involve a shift towards private sector providers of residential and home care services contracted by the state or by the family and individual care user, through public and/or private funding. Labour Force Survey data for the UK indicate that the proportion of foreign-born care assistants and home carers more than doubled from 8 percent in 1998 to 18 percent in 2008. The proportion of foreign-born nurses also increased from 13 percent to 23 percent over this period (Cangiano et al. 2009).¹ In Ireland, Census data indicate that the proportion of foreign nationals in the care workforce similarly increased from 11 percent in 2002 to 16 percent in 2006.

The employment of migrant care workers in western welfare states points to the ways in which migrant labor from the global South has serviced the care markets of the global North, enabling welfare states in the North to contain the costs of care (Williams 2011). While pressures for cost containment are central to the role of the market in welfare states, other policy aims also frame the implementation of market reforms to service provision. These include aims for improving the “personalization” of care to the needs and preferences of the individual. Although aims for cost containment and for personalization may be connected—in shifting responsibilities for care from the state to the individual—they may also expose contradictions and challenges in the operation of the market in welfare states. Those contradictions concern, on the one hand, the structural demand for low-waged care labor, which is both gendered and racialized as regards who those care workers are,

and on the other, the racialized preferences of individuals regarding who delivers their care.

This article explores these tensions at the microlevel of the relations between providers of long-term care services for older people, care users, and migrant care workers. It begins by situating the analysis within a framework presented by Williams (2011) for examining migrant care labor, which connects the institutional context of state policies towards care to the microlevel of care relations. The article then examines the market-oriented reform of long-term care for older people, and the specific institutional contexts of England and Ireland. The following sections draw on data collected as part of a cross-national comparative study on the employment of migrant care workers in residential care homes² and home care services for older people in England/UK³ and Ireland. The analysis focuses, first, on the ways in which divisions of race, ethnicity, and citizenship shape the preferences of service providers/employers and the preferences of some service users as regards who provides care. Second, it focuses on how the institutional context of quasi-markets in long-term care shapes the negotiation by providers of the employment of migrant care workers and the preferences of individual users, alongside the rights of care workers to non-discrimination. The article reflects on the implications of market-oriented policies for personalization, as well as for cost containment, for divisions of race, ethnicity, and citizenship in the provision of long-term care.

Care and Migrant Labor

There has been a growing body of research on the role of migrant labor in the provision of care in western welfare states. Williams (2011) presents a framework that integrates analyses of the macro-, meso-, and microlevels with respect to migrant care labor. Analyses at the macrolevel focus on the structural relationship between productive and reproductive labor in global economies and the social divisions of gender, race, and class that this relationship entails (Parreñas 2001; Yeates 2009). Those divisions involve the “international transfer of caretaking,” whereby the productive labor of (higher-waged) women and men in western countries is dependent on the low-waged care labor of female migrant domestic workers who in turn rely on the lower-waged and unpaid care labor of women in their countries of origin, such as the Philippines, in the provision of care in the household (Parreñas 2001). At the same time, the recruitment of migrant nurses in hospitals and residential care homes points to similar divisions of care labor in the operation of increasingly global care industries (Yeates 2009).

At the mesolevel, the analysis of migrant care labor focuses on state policies towards the organization of care (Williams 2011). With regard to childcare, Williams and Gavanas (2008) show how particular childcare “choices” among working mothers to employ migrant workers to care for their children are shaped not only by a lack of public childcare provision but by the nature of care policies and of “care cultures.” In the UK, cash allowances position mothers as individual consumers, choosing childcare within the market according to their preferences. In the context of long-term care, the public provision of cash transfers has similarly facilitated the employment of low-waged migrant workers to care for older people within the household in countries such as Austria, Italy, and Spain (Da Roit et al. 2007; Ungerson 2003). At the same time, state policies towards care connect with other policies, including immigration controls, which shape “choice” for migrant workers regarding their entry to and exit from care work through the differentiation of rights attached to citizenship and immigration status (Shutes 2012).

The microlevel within Williams’ framework focuses on the relationships between migrant care workers, their employers, and those for whom they care. As regards care work in the household, research has shown how the preferences of employers for migrant domestic and care workers are strongly shaped by race and ethnicity as well as by gender (e.g. Anderson 2007; Williams and Gavanas 2008). Racialized hierarchies and cultural stereotypes operate based on the categorization of the skills and characteristics of particular care workers according to race, ethnicity, and country of origin. Eastern European domestic workers may be favored over African workers, Latin American and Filipina domestic workers may be seen as more “loving,” and Eastern European workers as more “hard-working” by individual employers (Williams and Gavanas 2008). Employer preferences for migrant workers in different sectors of the labor market are likewise shaped by divisions of citizenship and immigration status (Ruhs and Anderson 2010). Perceptions of the “work ethic” of particular groups may be grounded in the relative control employers have over workers whose labor mobility is restricted by their immigration status (Ruhs and Anderson 2010). In the context of long-term care, there has been more limited exploration of the preferences of the individual service user, as well as service providers/employers, as regards the employment of migrant care workers. Racially discriminatory attitudes by older people towards black and minority ethnic nurses and care workers—citizen and “non-citizen” workers—have been documented by some studies (e.g. Berdes and Eckert 2001; Jönson 2007; McGregor 2007) as well as discrimination by co-workers and managers (e.g. Aboderin 2007).

Furthermore, there has been limited analysis of how the institutional context of long-term care shapes the negotiation by services providers of demand for migrant care workers alongside the preferences of individual users regarding who provides care.

Market Reforms and Long-Term Care for Older People

The provision of care for older people is situated within the ongoing restructuring of relations between the state, the market, the voluntary and community sector, the family, and the individual (Daly and Lewis 2000). Access to publicly funded care for older people in both England and Ireland is targeted on the basis of income and need. In Ireland, the public provision of long-term care can be described as limited and primarily directed towards residential care. As a consequence, the family remains the principal provider of care. While the provision of long-term care services in England may be more extensive in terms of levels of coverage of older people, the role of the family likewise remains central.

Developments in both countries, and across Europe, have brought about the increasing role of the market in long-term care (Pavolini and Ranci 2008). Market reforms have been pursued in relation to pressures for cost containment, but also for improving the “personalization” of provision to the needs and preferences of individual users (Needham 2011). Underlying these aims are differing political and theoretical critiques of the welfare state that give emphasis to the agency of the individual (Glendinning 2008). These include liberal economic perspectives that conceive of the market, as opposed to the state, as the most efficient means of allocating resources, positioning individuals as consumers within those markets in determining the allocation of resources to meet their needs and preferences. “Passive recipients” of care are reconstituted as “active consumers” whose ability to exercise choice within the market—particularly where purchasing power is transferred from the state to the individual—exerts competitive pressures on providers to be responsive to individual needs and preferences (Glendinning 2008). The ability to exit from provision—to choose between providers and services—is thus conceived as a key principle of the personalization of care to user preferences. At the same time, user-led perspectives have given emphasis to choice for disabled and older people over their care support as a social right, including choice over who provides care (Morris 2006).

The development of quasi-markets in long-term care has involved changes in the mix of funding of care services. Total expenditure on long-term care in the UK amounted to 1.37 percent of GDP

(in 2000), compared with a lower level of 0.62 percent of GDP in Ireland and an OECD average of 1.25 percent—Scandinavian countries having the highest levels of expenditure (OECD 2005). Public expenditure, until more recently, accounted for a greater share of total expenditure in both countries, but more so in Ireland (84 percent) compared with the UK (65 percent) (OECD 2005). More recent data for England indicate that private expenditure contributes around half of total expenditure on long-term care (Forder and Fernández 2010). The share of private funding is associated with increased targeting of public provision, including charges paid by individuals receiving public provision, extra support purchased by individuals in addition to public provision, and support that is entirely privately funded (Forder and Fernández 2010). Although private funding plays less of a role in Ireland compared with England, substantial shortfalls in the public funding of care mean that there is significant cost-sharing on the part of older people and their families. An inadequate supply of public residential care has led to older people entering private residential care where, even with public subsidies, top-up costs can be as much as two-thirds of the care fees (Callan 2009).

As regards the delivery of care, in both countries the private sector is the principal provider of publicly and privately financed services. In England, 81 percent of places in residential care homes are in the private sector compared with 13 percent in non-profit and 6 percent in public (local authority) care homes (Eborall et al. 2010). In Ireland, the insufficient number of places available in public residential care homes has similarly brought about an increase in the provision of residential care by private providers (delivering publicly and privately contracted beds): 62 percent of places in residential care are provided by private care homes, 29 percent by public care homes and 9 percent by non-profit organizations (Department of Health and Children 2008), reflecting the significant tax breaks brought to encourage the establishment of private care homes (O'Shea 2003). Home care services in England, which expanded considerably following the community care reforms in the early 1990s, are similarly mainly delivered by private providers: 76 percent of home care agencies are in the private sector (Eborall et al. 2010). The provision of home care services in Ireland, termed Home Care Support Packages, is comparatively much less developed; public funding has only recently (since 2005) been directed towards home care, which still represents a relatively small proportion of total long-term care expenditure. Along with being engaged in private service contracts with older people and their families, private home care providers are also contracted to deliver

public services as part of the Home Care Support Packages. While the number of private home care providers has increased dramatically in the last five years in response, in part, to the introduction of Home Care Support Packages, exact numbers are unknown due to an absence of regulation of the home care sector in Ireland.

In addition, both countries have implemented cash-for-care schemes that transfer the purchasing of care from the state to the individual user. These schemes, including Direct Payments and Personal Budgets in England and Home Care Grants (introduced as a part of Home Care Support Packages) in Ireland, provide those eligible with the option of receiving a cash payment to directly purchase care services and to directly employ care workers. In England, there has been a rapid increase in older people receiving Direct Payments (from 537 in 2001 to 20,610 in 2008), although the numbers of recipients still remain relatively low as a proportion of older people receiving publicly subsidized care (Eborall et al. 2010). By comparison, while cash-for-care payments remain less developed in Ireland—1,757 recipients of Home Care Support Packages were receiving a Home Care Grant in 2010 (Health Service Executive 2010)—the implementation of Home Care Grants has potentially increased private home care provision. The majority of grants are used to pay for private provider services or for directly employing a care worker (Timonen et al. 2006).

The specific institutional context of quasi-markets in long-term care thus frames the relations at the microlevel of care provision—between private providers contracted by the state or directly by the individual through public and/or private funding—and the ways in which particular demands with respect to care are negotiated.

Data and Methods

The following sections draw upon data collected in 2007–2008 in the UK and Ireland as part of a cross-national comparative study on the employment of migrant workers in the provision of care for older people. The data include, for both countries, national surveys of providers of care services for older people (residential care homes and home care providers) and follow-up telephone interviews with providers; focus groups with older people (aged 65 and over); and in-depth interviews with migrant care workers employed in residential care homes and in home care provision for older people.⁴

Care Providers

In the UK, a postal survey was sent to a random sample of residential care homes ($N = 3,800$) and a random sample of UK

Table 1. Sample of providers in the UK and Ireland by type of provider and type of service

Provider	UK			Ireland		
	Residential care (%)	Home care (%)	Total (%)	Residential care (%)	Home care (%)	Total (%)
Private	70	12	82	61	5	66
Non-profit	13	2	15	10	0	10
Public	3	0	3	23	0	23
Total	86	14	100	95	5	100
<i>n</i>	479	78	557	271	15	286

Homecare Association members ($N = 500$) (the survey was also made available online). The response rate was 12 percent ($n = 557$). As shown in table 1, 82 percent of the sample was private providers, 15 percent non-profit, and 3 percent public (local authority). Local authority providers were under-represented in the sample.⁵ Home care providers were also under-represented.⁶ While the sample is skewed to the private sector and to providers of residential care, national data sets (the National Minimum Data Set for Social Care in England and the UK Labour Force Survey) indicate that higher proportions of migrant care workers are found in the private sector and in residential care in England and the UK overall (Cangiano et al. 2009; Hussein 2011a).

In Ireland, a postal survey was distributed to all older adult residential care homes (public, non-profit, and private providers), and to 40 home care organizations that could be identified ($N = 570$).⁷ The response rate was 50 percent ($n = 286$). As shown in table 1, 67 percent were private providers, 10 percent non-profit, and 23 percent public. The sample in Ireland predominantly comprised providers of residential care.

Semi-structured telephone interviews were carried out with 30 providers in the UK and 16 in Ireland, selected from the survey respondents in the two countries (managers and owners of residential care homes and of home care agencies). The survey and interviews examined providers' reasons for and experiences of employing migrant care workers.

Older People

Five focus groups were held with a total of thirty participants in England, comprising: two groups with residents of care homes;

Table 2. Demographic characteristics of the migrant care workers interviewed in England and Ireland

	England	Ireland
Gender		
Female	49	29
Male	7	5
Nationality		
India	7	10
Philippines	13	10
Other Asia	3	—
Nigeria	—	5
Zimbabwe	15	1
Other Africa	4	1
Poland	4	1
Other Eastern Europe	10	6
<i>n</i>	56	34

two with home care service users; and one with community dwelling older adults who were prospective care users. They were white British nationals in four of the focus groups and British Asian (British nationals born in India) in one focus group. Three focus groups were organized in Ireland with a total of twenty-five participants, comprising two groups with residents of care homes and one with community dwelling older adults who were prospective users. The participants were all white Irish nationals (apart from one British national). In both countries, participants were predominantly female. The focus groups examined older people's perceptions and experiences of relations with migrant care workers.

Migrant Care Workers

In-depth, face-to-face interviews were carried out with fifty-six migrant care workers in England and thirty-four in Ireland. Participants were recruited through migrant, community and religious organizations, trade unions, care providers, and snowball sampling. As shown in table 2, most interviewees in both countries were women whose countries of origin (nationality) included the Philippines, India, Poland and other Eastern European countries, Zimbabwe and Nigeria. Most participants had arrived in the

Table 3. Employment characteristics of the migrant care workers interviewed in England and Ireland

	England	Ireland
Residential care		
Private	26	18
Public	—	6
Non-profit	—	1
Home care		
Private	10	2
Public	1	3
Directly employed	16	3
Residential and home care	3	1
Job role		
Care assistant or senior care worker	54	21
Registered nurse	2	13
<i>n</i>	56	34

UK/Ireland in the ten years preceding the research (since 1998). All were foreign nationals with different immigration statuses, including EU nationals, work permit holders, and those who held other types of immigration status (e.g. students).

As shown in table 3, around half of the interviewees in both countries were working in private residential care homes. Interviewees working in home care services were working mainly for private providers in England, public or private providers in Ireland, or were directly employed by the care user or their relatives. The interviews examined migrant care workers' experiences of relations with their employers and with care users.

The following sections examine, first, providers' reasons for employing migrant care workers (drawing on the survey of providers and interview data) and, second, the preferences of older people regarding their care workers. The latter draws on the focus groups with older people and also the interviews with providers and migrant care workers as regards their experiences and perceptions of racialized preferences among some service users. The third section examines how the institutional context referred to above—regarding type of provision and the financing and purchasing of care—shaped the negotiation of the employment of migrant care workers by providers.

Demand for Migrant Workers among Providers

Although the provision of long-term care continues to be heavily dependent on “non-migrant” citizen women, who have combined low-waged, part-time care work with unpaid care for families, significant difficulties in the recruitment and retention of care workers have been evident in England and Ireland (CSCI 2005; McCarthy et al. 2003). These difficulties are associated with the gendered low social status and low wages of care work, poor working conditions that include unsocial hours, and lack of opportunities for career progression (Moriarty 2010). The long-term care sector is one of the lowest paid sectors of the labor market in the UK (Low Pay Commission 2010). Wage data are not available for care workers in Ireland, but it is widely accepted that salaries in older adult care (particularly for care assistants) are similarly typically close to minimum wage levels. While care work is low-waged overall, higher proportions of foreign-born workers (79 percent) compared with UK-born care workers (54 percent) are employed in the private sector, where pay levels are lower and employment conditions less favorable (Cangiano et al. 2009). Indeed, there are higher proportions of foreign-born workers among the lowest paid care workers in the UK⁸ (equivalent data for Ireland are not available).

Among the care providers surveyed in the research, significant recruitment difficulties were reported. Half of the providers surveyed in the UK and Ireland reported difficulties in recruiting UK/Irish-born care assistants, while 58 percent in the UK and 80 percent in Ireland reported difficulties in recruiting nurses.

Providers in the UK identified low pay as the main reason for recruitment difficulties. Eighty-seven percent agreed that UK-born workers can earn more in other jobs and 74 percent that UK-born workers demand higher wages than those paid in the care sector. In follow-up interviews with private providers in England, low levels of pay were attributed to the low levels of fees paid to providers contracted by local authorities.

If we could pay twice the minimum wage then we could attract more local staff, and they would be more prepared to work those hours. But our funding is from the local council: 80 per cent of our clients are funded totally by the council. The council this year put the rates of pay to us for the clients up 2 per cent. But our costs have gone up to 5.8 per cent. There is no way I can recoup that. And so the staff are paid at a low level.

(Private care home, England)

In Ireland, 77 percent of providers considered recruitment difficulties to be due to the general shortage of Irish-born care workers in the older adult care sector. Providers indicated (in survey comments and follow-up interviews) that they perceived this shortage to be due to the poor pay and conditions in the private compared with public sector, the lack of professional creditability associated with working in older adult care, and poor career pathways.

The private sector is notoriously difficult to recruit Irish nurses [and] care assistants as it competes with the public sector which has more benefits and sometimes higher wages. (Private care home, Ireland)

Other difficulties in employing UK and Irish-born workers identified by the providers in both countries included an unwillingness to do shift work; the lack of the right work experience; and the lack of reliability among these workers.

In follow-up interviews, providers in both countries referred to difficulties in recruiting UK/Irish-born workers as the main reason for the recruitment of migrant workers.

There hasn't been availability of a local resource and in many cases they [migrant workers] are the only applicants for the job . . . the primary reason is that they are available staff at a given time for an organisation to take on . . . They are the current source of staff that are available for employment really. (Private care home, Ireland)

Providers thus attributed demand for migrant workers, on the one hand, to the perceived lack of availability of UK/Irish-born workers and, on the other, to their “need” for sources of low-waged labor. However, they also considered there to be advantages to employing migrant care workers. These advantages included perceptions of the better “work ethic” of migrant workers compared with UK/Irish-born workers.

The biggest advantage is that they turn up for work. Their absenteeism is very, very minimum. It is the exact opposite with Irish workers . . . Very reliable. (Private care home, Ireland)

To be honest with you, migrant workers, particularly the Filipinos and Chinese, have a better work ethos than the majority of British people. They are more inclined to buckle down and get on with it . . . whereas some British people will just take the job because they need to get off the dole and for them it is a stepping stone. (Private care home, England)

Perceptions of the “work ethic” of migrant workers drew on cultural stereotypes accorded to different countries of origin: “Filipino workers are more industrious, more hard working”; “Polish people are very hard-working”. These hierarchies of skills and characteristics also operated in relation to providers’ perceptions of a “caring ethos” among particular groups: “Filipinos, they’ve got that lovely soft approach”. Perceptions of the advantages of migrant workers as a source of care labor were, however, also shaped by the effects of immigration controls. While EU nationals from Eastern European countries were seen as “hard working” they were also perceived by some providers in England as less reliable in that, like British workers, they did not face restrictions on their labor mobility. Care-related jobs could, therefore, similarly be a “stepping stone” into other types of work. By contrast, migrant workers from countries such as the Philippines who were employed on work permits (for senior care workers and nurses in the UK and for care assistants and nurses in Ireland) were dependent on their employers for their work permits and for their temporary rights to work in the UK and Ireland. They were thus perceived by some employers as providing a more retainable source of “hard working” care workers over whom employers had greater control.

The advantages are actually that I know that I’ve got a workforce for five years, because they are on five year visas.
(Private care home, England)

User Preferences for Who Cares

While providers’ reasons for employing migrant care workers, overall, related to difficulties in attracting UK/Irish-born workers to take up low-waged, low-status jobs in care for older people, they faced other competing demands as regards their workforce. Within the focus groups with older people, participants generally referred to positive experiences of relationships with migrant care workers in residential and home care provision. Relatively few participants referred directly to race and ethnicity as influencing their preferences for and attitudes towards care workers: one home care user in England indicated that although “colour shouldn’t matter” with regard to the carer, for her it did. However, preferences for “English carers” and for “Irish carers” were conveyed by some older people in terms of the importance they placed on the English language proficiency of care workers, referring to communication difficulties experienced with care workers of particular countries of origin who

had limited English language proficiency or whose accents older people found difficult to understand.

Well, I'm not being biased, but I like the English girls. I think the trouble, it's these barriers that causes the trouble. Like especially the language. And they get it wrong at times. They misunderstand and then they get things wrong. . . The Polish girls seem to have dominated in my life and they were the ones for who, you know, the language was very bad. (Female care home resident, England)

From African countries they've all got their own patois, or whatever you call it, accent, they all speak differently and I just cannot understand them. (Female home care user, England)

If you're dealing with a migrant . . . they don't understand you and you don't understand them. (Male prospective care user, Ireland)

Within the focus groups conducted in England, British Asian participants for whom English was not a first language also expressed preferences for care workers from their country of origin in terms of their language needs.

But I would want someone typically Asian, who speaks my language so I can communicate. (Male home care user, England)

Providers in Ireland similarly referred to the other language needs of care users who only spoke Irish Gaelic.

Preferences for “English carers” were also defined in terms of wanting a care worker with whom they could share the same sense of humor, or whom they could trust to care for them in their own home. By contrast, “foreign care workers” were perceived as having different social and cultural backgrounds, and different norms and attitudes to the care user.

The salience of race in shaping the attitudes of some care users was more strongly vocalized by the migrant care workers and by the providers interviewed in England and Ireland. Care workers from Zimbabwe, Nigeria, and other African countries, in particular, referred to experiences of older people refusing to be cared for by them.

Where I used to work, there used to be a woman who said, “Can you send me a carer but not a black one please”. (Female Zimbabwean home care assistant, England)

I had one time . . . one lady . . . she was very agitated and she kept on ringing her bell and one time I said “are you

ok?” and she goes “listen just go away! I don’t want a black nurse around me. . . I don’t want. . . I want my own Irish nurses.” (Female Zimbabwean care assistant, public care home, Ireland)

These attitudes also extended to experiences with the families of care users, regarding who they considered appropriate to care for their relatives.

Some families having really problems, really challenging like - they don’t like us, we are from another country. . . You know they are just giving out to us “where did you study?”, “where do you come from?” (Female Indian nurse, private care home, Ireland)

Eastern European care workers in England noted that they were sometimes favored by older people compared with Asian or African care workers for being “white”, pointing to the intersection of race and country of origin in hierarchies of care workers.

Care providers interviewed similarly referred to the racialized attitudes of some of their users towards care workers. Language barriers were considered by providers to impact negatively on older people’s experiences of and attitudes towards some migrant care workers. However, residential and home care providers also stressed the ways in which divisions of race shaped the attitudes of some users towards care workers, irrespective of language difficulties. Indeed, home care providers in both England and Ireland (in their survey responses and in follow-up interviews) referred to some clients refusing to be cared for by migrant workers.

We’ve only got one client who’s not white English. And a lot of them, particularly if they are coming from a slightly less educated background, are quite prejudiced and therefore trying to put a non-white English carer in there is a problem. . . It’s not really with the skills or the language of the migrant worker, it’s the fact that if they appear at the door, the door will be shut in their face. (Private home care provider, England)

The intersection of race, ethnicity, and nationality with other social divisions, notably gender and age, was also apparent as regards who was considered to be an appropriate carer. Female residents of a care home in England referred to preferences for “English girls”, while in Ireland, home care providers referred to middle-aged Irish women as being at the top of the pecking order.

Everybody we speak to wants a middle-aged Irish woman as a home care worker. . . because she is going to be that perfect care giver. (Private home care provider, Ireland)

Although the majority of foreign-born care workers are women (76 percent), there is a higher proportion of men among foreign-born care workers (24 percent) compared with UK-born care workers (of whom 87 percent are women and 13 percent men) (Cangiano et al. 2009). Male migrant workers in the care sector in England are mainly working in residential care (Hussein 2011b). Among the male care workers interviewed in the research (who were working in residential and home care provision), some referred to female and male care users not wishing to be cared for by them.

Some people doesn't like men, you know. So they won't let us do . . . also they are giving in writing "I think it should be a female carer". It's a personal thing [. . .] They won't like men, that's all. (Male Indian care assistant, private nursing home, Ireland)

At the same time, there was some indication from the focus groups with older people (who were predominantly women) of the ways in which gendered and racialized preferences for who provides care may differ according to the type of care support provided.

I think a woman should be cared for by a woman and a man by a man. It's very embarrassing otherwise.
(Female care home resident, England)

One of our ladies where I live, she's got a man, a black man, who's about 6ft3" and he's marvellous, a lovely man, and a young man, and he is wonderful, marvellous worker. [. . .] He only cleans I think, because he does the shopping and all that sort of thing as well. He wouldn't bath her or wash her, I'm sure he doesn't.
(Female home care user, England)

Negotiating User Preferences, Discrimination and Demand for Migrant Labour

Experiences and perceptions of the racialized attitudes of some older people towards who delivered their care presented providers with potentially conflicting demands: the “needs” of providers for migrant care workers as a source of low-waged labor; the preferences of some of their service users; and the rights of care workers to non-discrimination in employment on grounds of race, ethnicity, and national origin. The response of providers to these conflicting demands was partly shaped by the type of care service provided. In the context of home care, one response was to decide not to employ migrant care workers. In Ireland, one home care provider indicated that they were reluctant to employ migrant workers because of their

experiences of particular workers not being accepted in the private sphere of the homes of their service users.

[Home care] is very different to working in a nursing home because the difference is you are going into somebody's home [. . .] it can be problematic for the clients even if they got an Irish person going in there. We're going in and people like their privacy. . . We did have two girls [Nigerian care workers] coming from a different scheme in the city and it did not work out at all. (Private home care provider, Ireland)

The decision to select out migrant care workers was in some cases also related to the gendered provision of particular types of care work. A male migrant care worker in Ireland indicated that he had not been recruited by a provider on grounds of the gendered delivery of personal care.

I also applied there at [another nursing home]. They don't accept male, only female [care workers], because female can handle male residents. (Male Filipino care assistant, public home care organisation and private nursing home, Ireland)

An alternative response, evident among some of the home care providers in England, was to avoid placing black and minority ethnic care workers with a service user who refused to be cared for by a “black carer” or was racially abusive towards the care worker.

On the risk assessment with the client they try to find out everything about them. And if they notice something like that they don't direct some black carers to them. . . they don't want to make them upset or worse. (Female Polish care assistant, residential care home and home care agency England)

While the racial “matching” of care user and care worker enabled home care providers to manage the racialized demands of some of their users, locating this strategy within a market-based discourse of personalized care served to legitimate it as provider responsiveness to the preferences of consumers. Although some providers recognized their duties to comply with race discrimination legislation, they emphasized their role as market actors in responding to the individual preferences of service users whom they prioritized as their “customers”.

We have obviously got to keep our service users happy, that's number one in business, keep your customer happy. And obviously we've got to look at the law as well, with the equal opportunities. But we always try to match the carer to our

service users . . . if they are very adamant about a particular carer, whether it's just the look about them, the colour or they don't like the personality, we do try and fit the carer with the service user. (Private home care provider, England)

Whether or not providers sought to respond to the racialized demands of some of their users—either through their recruitment practices or the allocation of staff—was partly mediated by the institutional context in which they operated. As regards the financing and the purchasing of care, providers referred to the racialized demands of both privately paying clients and those whose care was publicly arranged through local authorities.

Probably one in three of our enquiries for private pay will at some point specify they don't want a black person or a foreigner in there. And with Social Services sometimes you'll find that Social Services will actually go off the record and they'll say that Mrs X will not accept black people or foreign people. (Private home care provider, England)

However, care users who were privately funding their care were referred to (by another private home care provider) as being more able to vocalize their preferences through the direct purchasing of care services, potentially being able to select providers that best met those preferences.

If it's a private client coming to us, obviously they will vet us and ask us questions . . . I mean some of them do shop around. What we'll do then is we'll send somebody out to go and meet them and do an assessment on them and . . . it will be at that point that they'll request whether they like a female carer, whether they don't mind male carers, and they'll probably say "I don't want somebody different every day" or "I don't want, I want somebody who you know can understand me clearly" they'll say their preferences what they like and dislike so we can match the suitable carer. (Private home care provider, England)

In contrast to England, although some care users in Ireland may be privately paying for their care, the more limited development of a market of alternative providers (particularly for home care services) would potentially limit the ability of privately paying individuals to be selective and to "shop around". Likewise, some providers were better resourced than others and, therefore, potentially more able to select their staff according to the perceived preferences of their service users. A residential care home in England, which was

privately financed by more affluent older people and their relatives, indicated that it had been able to select “local” workers on the basis of having the resources to offer higher levels of pay.

We are a very upmarket care home, we're very expensive and quite exclusive. One of the big advantages for us is the sense of community that exists in the home, and that community is generated by having local staff who understand the local issues, who are able to relate to relatives of residents . . . We haven't gone down the route of using agencies and overseas staff. The way that we are able to maintain our workforce and strengthen our workforce is on the basis of paying that higher rate of pay than anybody else.

(Private care home, England)

Funding pressures, low wages, and staff shortages (and, related to this, a reliance on migrant workers) limited the potential for some providers to be selective in their recruitment or in the allocation of care workers according to user preferences. Indeed, resource constraints may have contributed to what appeared to be more of a concern with low levels of funding and staff shortages than with consumer choice among some providers in England and Ireland.

Lack of funding is horrendous really [. . .] to fund an elderly person seems to be a dirty word in this country. . . the fact that they were healthy for eighty years and cost nothing; now that they're coming into long-term care they are seen to be a problem.

(Private care home, Ireland)

Within this context, some migrant care workers referred to being required by their managers to care for particular individuals against both the individual user's and, not least, their own preferences, having to “put up with” racist verbal abuse.

Sometimes you are put in a situation when you are not really welcomed in the house, but the client doesn't have a choice who they have to put up with and we have to put up with them.

(Female Zimbabwean live-in care assistant, England)

Sometimes . . . [the clients] feel “oh I have no choice, I'll just take her.” But . . . when they take you on, you read them, you read it all over them, if they really want you . . . I did just two days, and it was hell. It was hell. Because I'm black, he doesn't want me.

(Female Nigerian home care assistant, Ireland)

While a market-based discourse of personalized care served to counteract racialized preferences among users, it exposed tensions not only with demand for migrant workers among providers but with

the rights of care workers relating to race discrimination in employment. Migrant care workers who had vocalized those rights by reporting to their managers their experiences of racist verbal abuse referred to varying responses among providers to those experiences. Limited action by providers was indicated by some care workers.

You can't really answer back, you can't really do anything about it, the only thing that you can do is probably walk away and set up an incident report and issue an application for a management hearing. . . You can report it to management, but most of the time nothing really happens. (Male Zimbabwean home care assistant, England)

Minimal action was partly legitimated by providers through the privileging of user choice, emphasizing the relative power of users who were more “vocal” and who were able to exercise choice over their care through exit.

I ask them [care users] not to say anything. But it's quite difficult really because some are quite vocal and it's not an awful lot that I can say really. And they've got a choice at the end of the day. (Private care home, England)

The rhetoric of user choice was, however, more evident among the providers in England compared with Ireland, potentially reflecting the relatively greater development and promotion of user choice models in long-term care policy in England.

Minimal action was also legitimated both by providers and by migrant care workers by rationalizing race discrimination as the “pathology” of older people (Jönson 2007), as either inherent to the generational attitudes of older people, “fear of the unknown,” or the “challenging behaviour” of older people with dementia.

People of 80 and 90, would not have grown up in this kind of an era. (Private care home, Ireland)

It was also legitimated in terms of the professional duties of care workers in caring for older people. In contrast to the positioning of users as vocal “choosers” by providers, migrant care workers were sometimes presented with limited “choice” as regards their preferences for whom they provided care. Indeed, migrant care workers were in some cases obliged by managers to continue to care for racially abusive clients on grounds of their duties of care.

The manager said “There's nothing you can do. When she [the user] says that, you walk away from the room and go back again,” because I reported it. Then I said, “I don't want to go

to that room any more.” But the manager said, “You have no choice. A carer has to go there.” They said, “If you don’t, if you leave her like that, it’s abuse.” But the resident was abusing me. (Female Zimbabwean care assistant, referring to experiences of working in a care home, England)

By contrast, some migrant workers indicated the attempts of providers to act on their discrimination rights.

The agency I work for, they emphasise that they don’t tolerate this. So if anyone ganged up on a black person or an Asian, they will send a person there, because they seriously do not want to put up with it. (Female Zimbabwean live-in care assistant, England)

Likewise, some providers indicated that they had refused to comply with the racialized demands of particular users for particular care workers.

I worked very hard when they came in first trying to police it, because it was the resident who was abusive to the [migrant care workers] and not the other way around. (Private care home, Ireland)

However, overall, the findings point to the potential contradictions and challenges stemming, on the one hand, from the employment rights of care workers with regard to discrimination, and on the other, from the policy and practice of the personalization of care to the preferences of individual users within a quasi-market of service provision.

Conclusion

Demand for migrant care workers among providers in the UK and Ireland, overall, reflected difficulties in the recruitment of low-waged care workers, the majority of whom have historically been women. However, providers also expressed preferences for migrant workers grounded in perceptions of the “work ethic” and “care ethic” of particular groups. Indeed, providers sometimes placed particular groups, such as Filipino workers, at the top of their pecking order. Racialized and cultural stereotypes, but also the terms and conditions of the immigration status of migrant workers, contributed to perceptions of migrants as “good care workers” among providers. The preferences of older people as regards who delivers their care may, however, involve conflicting dynamics of race, ethnicity, and citizenship. Concerns among older people with

respect to English language and communication needs were partly expressed as preferences for English and Irish care workers in some cases, or for workers of other national origins among older people with other language needs. However, divisions of race also shaped the experiences of both providers and migrant care workers as to whom some service users would accept as their carer. Those experiences reflect the findings of other research with regard to discrimination faced by black and minority ethnic care assistants and nurses—both citizen and non-citizen workers (Berdes and Eckert 2001; Jönson 2007; McGregor 2007).

As feminist scholarship has conveyed, the question of who provides care requires attention to gendered norms and identities. The provision of long-term care services by migrant women and men points to the intersection of divisions of gender, age, race, ethnicity, and citizenship, regarding not only who provides care, but which types of care support, for which service providers, and for which groups of older people. The construction of gendered and racialized preferences by service providers/employers and service users in long-term care shows similarities with research on care work in private households (Anderson 2007; Williams and Gavanas 2008) as regards which groups are perceived as “good” care/domestic workers. However, in the context of service provision, the negotiation of who provides care by contracted private providers involves a potentially wider range of competing interests, legal rights, and duties with respect to public and private purchasers, care managers, service users, and care workers.

The specific institutional context of quasi-markets in long-term care frames how, at the microlevel, providers of care services negotiate the employment of migrant care workers, the preferences of individual service users, and also the rights of care workers. That context involves differences in the type of provision. Home care providers had potentially greater capacity to “racially match” care workers and users in the context of care provided in the home of the individual user in contrast to providers of residential care. Likewise, residents of care homes were potentially less able to exit from providers that did not meet their preferences as regards their carer. However, differences in the supply of alternative providers may also affect the extent to which care users are able to select provision according to their preferences. In Ireland, although providers noted the preferences of some older people for “Irish carers”, the provision of home care services and a market of alternative home care providers are more limited in contrast to residential care. This may partly account for less emphasis given to older people and their families acting as market agents by the providers in Ireland compared

with those in England. Differences in the resources of providers to be selective in their staffing practices, and in the resources of older people to be selective in choosing their care, also shape the negotiation of who provides care. Where pressures to contain the costs of care took precedence—reflected in the under-funding and understaffing of provision—providers were potentially less responsive to the demands of individual older people or indeed to the rights of care workers to non-discrimination.

Market-oriented policy aims for personalization, as well as for cost containment, thus raise implications for divisions of race, ethnicity, and citizenship in increasingly marketized and privatized systems of long-term care, as regards the financing, purchasing, and delivery of services. By framing the provision of care in terms of the responsiveness of providers to the preferences of the individual service user, racialized hierarchies for the selection of care workers, and their allocation to individual users are potentially legitimated. Moreover, by shifting responsibilities from the state to the individual and family for both the financing and the direct purchasing of care provision, providers may face greater pressures to be selective according to those preferences. At the same time, divisions among older people—between those with greater or lesser purchasing power on the basis of private finances and other resources, between those who can “shop around” and those whose access to provision is much more restricted—may leave some groups of older people with very limited choice, if any, over their care workers. This may be particularly the case in Ireland given the limited alternatives within long-term care services. In the light of major cuts in public expenditure, pressures for cost containment in long-term care in both England and Ireland, and elsewhere in Europe, may reinforce those divisions.

More broadly, however, these dynamics at the microlevel of the relations between private providers, service users, and care workers point to the limits of framing care in terms of the allocation of resources within a market according to the preferences of the individual. The ability of older people to act as individual consumers, exercising choice as regards who provides care support is, not least, highly dependent on their purchasing power in publicly and privately funded quasi-markets of care. However, the construction of the care user as the “unencumbered” liberal self (Sandel 1996, cited in [Daly and Lewis 2000](#): 292)—as the individual consumer who enters and exits from care according to their autonomous will—underlines the tensions between market principles and the social relations in which care is embedded. As emphasized by [Daly \(2002\)](#), care is a policy good with two sets of interests: those of the person

experiencing care needs and the actors who provide it. The vulnerabilities of older people and their experiences of power inequalities as users of care services stand alongside the experiences of inequalities by migrant care workers. Divisions of race, ethnicity, and citizenship partially disrupt the binarism of the “dependent” older person in need of care and the “independent” giver of care, and draw attention to shifting relations of power. In contrast to the liberal principles of the market, the principles of an “ethics of care” (Williams 1999) move beyond an individualist focus on the preferences or rights of the individual. While an ethics of care does not address the structural basis of the divisions of care labor, it attends to the importance of an approach to care that positions social relations, rather than autonomous selves, as central to the provision of care. To return to the macrolevel in Williams’ framework, it is, however, important to place those social relations at the microlevel of care provision in a global context.

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NOTES

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1. Data on the adult care workforce in England in 2011 indicate that 19 percent of workers are foreign nationals (Skills for Care 2011).

2. The term ‘residential care homes’ is used in this article to refer to all long-stay care homes, including those that provide nursing care facilities.

3. A distinction is made where the data refer to England or to the UK.

4. The survey questionnaire, interview, and focus group guides included a comparative set of questions and topics. See Cangiano et al. (2009) and Walsh and O’Shea (2009) for details on the research methods.

5. Six percent of residential care homes and 12 percent of home care agencies registered with the Care Quality Commission (CQC) in England are local authority providers.

6. The sample comprised one home care agency for every six providers of residential care for older people, while the same ratio among all providers registered with the CQC is one in three.

7. Home care is not regulated in Ireland and the exact number of providers is unknown.

8. Labour Force Survey data for 2008 indicate that 42 percent of foreign-born care workers who entered the UK since 1998 earn less than £6 per hour gross, compared with 31 percent of UK-born care workers (Cangiano et al. 2009).

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