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Marginalised Care: Migrant Workers Caring for Older People in Ireland

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Abstract Older adult care in Ireland is a mix of public, private, voluntary and family provision. This model is characterised by deficient funding and support structures for both care recipients and carers, leading ultimately to fragmented service delivery, both in the community and in residential care. Against this backdrop, there has been a significant and rapid growth in the number of migrant registered nurses and care assistants providing care to Irish older people. With two potentially marginalised groups now at the centre of the caring relationship, questions arise regarding the sustainability of quality of care and quality of life for both providers and recipients of care. This research study draws on the perspectives of the older person, the migrant carer and the employer to develop an understanding of migrant worker care provision within the disadvantaged ageing sector in Ireland. The paper will frame migrant care workers' experiences within the perspective of a marginalised sector, whose central consumers, older people, are not prioritised in policy or practice. Providing evidence of disadvantage for older adults and migrant carers, the research findings demonstrate that it is necessary to improve caring experiences and conditions for both groups if quality of care is to be enhanced.

Keywords Migrant care workers · Older people · Older adult care · Marginalised care · Quality of care

Introduction

This paper explores the relationship between the state of the older adult care sector in Ireland and the experiences of migrant care workers delivering care to Irish older people. The research is based on Irish data collected as a part of *'the role of migrant*

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care workers in ageing societies' research study and draws on the findings of the Irish national report (Walsh and O'Shea 2009).

As with the UK, the US and Canada, foreign national carers (i.e. registered nurses and care assistants¹) feature strongly in the Irish older adult health and social care sector. Unlike the other project sites, Ireland has only recently established itself as a host nation, both for general labour migration and care workers (Barrett 2005; NESCC 2006). Traditionally seen as a sending country, labour outward migration was synonymous with Ireland for much of the 20th century (particularly the 1930s, 50s and 80s) and was responsible for significant declines in the national population. At the end of the last century and the beginning of this one, these circumstances were reversed when approximately ten per cent of the nation's population (4,254,000—CSO 2006) were foreign national citizens. While there is concern that the current economic decline will reverse this trend again, Ireland is now very much a multicultural society—perhaps though, more in population structure than in philosophy.

It was not until the late 1990s that an observable proportion of immigrant workers were present in any Irish labour market sector (Ruhs 2005; Humphries et al. 2008). Yet, the percentage of migrant workers in health and social care is now on a par with, or greater than, our international counterparts (OECD 2007; CSO 2006). Moreover, projections of demand for carers suggest that the ageing of the Irish population could increase our need for migrant carers nine fold by 2035 (Barrett and Rust 2009). The rate at which the migrant care workforce is growing in Ireland raises questions for older adult care around strategic and preparatory planning, the coordination of cross-sector regulatory structures and the management of a multicultural labour force.

There is an extensive literature documenting the reliance on migrant carers in developed western health and social care systems (Pittman et al. 2007; Buchan 2007; Lorenzo et al. 2007; Khadria 2007). However, these studies primarily concentrate on high-skill health professionals and rarely recognise the specific specialities and context of sub-sector care regimes. Migrant carers who care for older people have not received the attention they deserve in the international literature and are not considered in any significant way in policy and practice domains in Ireland (Health Service Executive 2008). Given that there are now two vulnerable groups at the centre of the care relationship, this lack of data and the absence of a relevant policy focus are a concern. The synergy of health and social services through a mix of public, private and voluntary provision, coupled with a consumer group who demographically have been viewed as disadvantaged (Minichiello et al. 2000; Price 2006), introduce a particular set of circumstances within which migrant carers work. The intricacies of the older adult care sector do not stop there. There is recognition that there are several fundamental issues that threaten the effectiveness of care for older people in Ireland.

Eleven per cent of Ireland's population is over the age of 65 years (EU 27 average 16.8 per cent) and can be considered relatively homogenous with respect to culture and religious background (i.e. primarily Caucasian and Roman Catholic) (CSO 2007). Research has shown that the majority of Irish older people want to remain

¹ Care assistants are equivalent to direct care workers in the US/Canada and social care workers in the UK.

and to be cared for in their own homes and communities (Garavan et al. 2001; Williams et al. 2005). At the same time, the formal structures for older adult care provided by the Health Service Executive (HSE) are still based on an institutional model of care provision (NESF 2005). This also seems contrary to the established needs of the older population in Ireland. Five per cent of older adults live in long-stay facilities, whereas 15–20 per cent of those living outside institutions require care (Mercer 2002). While a call for an official community care infrastructure was first made in 1968 (Department of Health 1968), and later echoed in 1988 (Working Party on Services for the Elderly 1988) and 2001 (Department of Health 2001), it was not until 2005 that statutory home support packages were introduced. Their provision, however, is limited, thought to be service fragmented, regionally disjointed and based on a set of criteria that are discretionary in nature (O'Shea 2007). Even with an increasing number of private home care providers in Ireland, the majority of community care (and care as a whole) is still provided by family, friends and voluntary and religious organisations (Walsh and O'Shea 2008; Timonen and Doyle 2008).

In the case of older adults in residential facilities, concerns are evident at several levels. The existing funding system for public provision is considered inadequate to meet the demand for care; it has been linked to inappropriate placement and inequity of supply; and its allocation criteria lack transparency (O'Shea 2003). Although a new funding model, through a retrospective payment based on housing assets, has been introduced it is unclear at this early stage if this new model will be successful. There are more serious concerns around the quality of care in our institutions. Staffing ratios, staff training, resident autonomy and the level of rehabilitative and ancillary care services have all been identified as issues in Irish residential settings (Murphy et al. 2006; O'Shea 2003; Walsh and Waldmann 2008). More worryingly, incidences of neglect and even abuse have come to the fore in some recent high profile cases (Leas Cross Review 2006; The Commission of Investigation 2009). The regulatory structures for residential facilities in Ireland, which were administered by the HSE, were not sufficient to address these issues, and focused solely on private provision. Subsequent demands for regulatory reform led to the introduction of the 'National Quality Standards for Residential Care Settings for Older People' in March 2009, followed by the enacting of an independent Social Service Inspectorate for all residential facilities in July 2009. Home care provision, which has experienced rapid growth in the last 5 years, remains completely unregulated whether it is provided by statutory, voluntary or private means.

For many, the issues with older adult care provision and regulation are indicative of a marginalised sector that suffers from low-levels of exchequer spending. An estimated additional €500 million is required before Ireland's long-term care expenditure matches the OECD average (NESF 2005). To secure suitable standards of quality of care and quality of life for older people, recent reports and policy documents have emphasised the need for a person-centred approach (NESF 2005; Murphy et al. 2006). The current problems in the sector—particularly in regard to funding, prioritisation and regulation—pose serious challenges to the realisation of person-centred care and to the care of dependent older people in the country. The question then is how do these sector characteristics impact on the migrant carers providing care to Irish older people?

For migrant workers generally, regardless of the sector of employment, there are a number of issues. Problems with language and communication, access to information, cultural associations, an absence of social and support networks, and a susceptibility to both societal and workplace discrimination are just some of the factors that affect labour migrants internationally (Winkelmann and Winkelmann 2002; Omeri and Atkins 2002; Alexis et al. 2007; Larsen 2007; Loveband 2004; DiCicco-Bloom 2004; Kyraiakides and Virdee 2003). Ultimately, these factors can negatively impact on the social and labour market integration of immigrants working in host countries (Orsetta and Sébastien 2006; O'Connell and McGinnity 2008). Research carried out in Ireland has suggested that, even with comparable qualifications and experience to indigenous workers, migrant workers have not successfully integrated (i.e. salary and promotion attainment not matching Irish labour force) into the Irish labour market (Barrett and Duffy 2007; Gonzalez-Perez et al. 2005).

Immigration and employment regulations too have proved to be a problem generally. The application criteria, the bureaucratic process and the bonded employer contracts of some government regulations have all been documented in the international literature as issues for labour migrants (Royal College of Surgeons 2008; Piper 2004; Ruhs and Anderson 2006). In Ireland, non-EEA workers are required to obtain an employment permit, of which there are two kinds. The first, a green card, targets high-skilled professionals. Applicants must earn in excess of €60,000 per annum or belong to an occupation that is in short supply and pays between €30,000 and €60,000 per annum. Registered nurses are considered to be in the latter category. A green card lasts for 2 years after which time it is intended that it can be renewed indefinitely. The second permit type is the work permit, which is granted on the basis of an EEA labour market needs test and a yearly minimum salary of €30,000 or more per annum. The work permit lasts for 2 years, with the first year fixed to a specific employer, and can be renewed for a further 3 years (Department of Enterprise, Trade and Employment 2007). Care assistants in theory can apply for a work permit, but the minimum salary requirement can be restrictive, confining employers to existing labour pools within the EEA. In addition, since April 2009 domestic workers are no longer allowed to apply for a work permit (Department of Enterprise, Trade and Employment 2009). This change precludes non-EEA carers employed directly in the home, but it is not clear if it affects care assistants hired by an external third party.² Older adult care workers can also enter Ireland through the family reunification and the asylum process. While EEA labour migrants (including those from the ten accession countries) do not require a permit to work in Ireland, there are two exceptions: Romanian and Bulgarian nationals, along with nationals of non-EEA Eastern European countries (e.g. the Ukraine, Croatia and Albania), are subject to the same immigration restrictions as other non-EEA nations.

There is evidence to suggest that working in a sector that is marginalised and that is not strictly regulated, serves to intensify the problems and challenges for labour migrants (Keung Wong et al. 2007; Anderson 2000). Studies have shown that in these situations incidences of exploitation and labour law violation are more difficult

² Prior to regulatory reform in 2007, non-EEA care assistants could apply for a work permit and would not have been subject to the same level of restrictions.

to identify (MRCI 2004, 2008). While much of this research concentrates on other sectors of employment, the issues inherent within older adult care may mean that migrant carers could experience an additional, and sector induced, disadvantage. This in turn may impact on the quality of care delivery.

However, because of the lack of data on migrant carers in the older adult care sector, particularly for the Irish context, it is difficult to approximate the true implications of these circumstances. Consequently, the research documented in this paper aims to investigate if the marginalisation of older adult care in Ireland exacerbates the disadvantage of migrant care workers and explores the affects, if any, on the working lives of carers and the quality of care available to Irish older people.

The 'social nature of labour' (Peck, 1989)—social division influencing employment opportunities—provides a basis for understanding the experiences of migrant workers in the labour market. Conversely, to reflect the context of the structural changes in older adult care, with respect to location, provision and funding of care, elements of network based approaches (O'Doherty, 2006)—networks as sources of social and financial capital—can be related to older people's capacity to access care. This paper draws on the conceptual underpinnings of both sets of theory as the theoretical framework for this research.

Methodology

In this study, conducted from 2007 to 2009, three primary research strands were developed around the migrant carer, the older adult care recipient and the employer. This strategy allowed for a comprehensive exploration of migrant care provision and facilitated a holistic understanding of the relationships and dynamics that exist within the older adult care sector. Quantitative and qualitative³ techniques were used to gather the information and as a means of including macro and micro data. Through the use of multiple methods of data collection and multiple informants (i.e. older people, migrant care workers and employers), this mixed method approach, and triangulation of information sources⁴ ensures that all the necessary dimensions and perspectives are included in the research enhancing evidence-based analysis and interpretation of the data (Jick 1979; Shih 1998; Duffy 1987; Sale et al. 2002). In addition, a series of background components (e.g. stakeholder focus groups) were used to inform the design of the study.

Migrant Care Workers

Semi-structured interviews were conducted with 34 migrant care workers. A focus group was conducted with a further six migrant carers. Overall, 17 registered nurses and 23 care assistants, from across public, private and voluntary institutional and

³ A thematic analysis was performed on the qualitative data with the use of Atlas TI qualitative data analysis software.

⁴ In the context of this study the triangulation of information sources refers to using multiple sources (in this case older people, migrant care workers and employers) to understand a single phenomenon—it does not refer to the combination of multiple and mixed methods, which are instead treated as complimentary sets of findings and are integrated at the level of analysis and interpretation (Moran-Ellis et al. 2006).

home care settings were included in the study.⁵ Participants came from India, the Philippines, the EU-accession countries (i.e. Poland, Latvia and Lithuania), the Ukraine and a number of African countries, with length of Irish residency ranging from 1 month to 7 years. Ten participants were in the 20–29 age group; 21 participants were in the 30–39 age group; four participants were in the 40–49 age group and five were in the 50–59 age group. All nationalities were represented and primarily concentrated in the 30–39 age group. Outside of acute care settings (for nurses) and informal care provision to relatives, none of the participants had formally cared for older people prior to coming to Ireland. Individuals were recruited from migrant and community organisations and health and social care networks across three regions in Ireland. Efforts were also made to recruit undocumented workers, but this was not successful.⁶ The interview and focus group topics of interest included the following:

- Decision to enter older adult care
- Responsibilities and challenges in current position
- Working relationships
- Impact of migrant status on experiences

Older Adult Focus Group Discussions

Three focus group discussions were organised with older adults. In all, there were 25 participants, who included community dwelling older adults (prospective users of care) and nursing home residents (current users of care). The nursing home residents were of low dependency and resided in a 47-bed facility staffed by 31 carers, 48 per cent of whom were foreign nationals. Although the agenda differed for the community participants and nursing home residents, reflecting the groups' different perspectives, the broad topics of interest remained the same and included the following:

- Attitudes to a multi-cultural Ireland
- Preferences and plans for care
- Experiences of and attitudes towards migrant carers
- Positive and negative aspects of being cared for by migrant carers

Employers

A postal survey was distributed to all older adult long-stay care institutions (public and voluntary facilities and private nursing homes) in Ireland, and to as many home care organisations as could be identified from a variety of sources ($N=570$). Fifty per cent of surveys were returned. The purpose of the survey was to gather information

⁵ Three of the care assistants in this study were hired directly by older people and/or their families as live-in carers. While there is no official data available on the number of migrant 'direct hires', anecdotal information would suggest that this form of employment still encompasses a relatively small proportion of the care workforce.

⁶ Data on undocumented workers in the older adult care sector is primarily anecdotal, with little certainty about actual numbers.

on reasons for hiring, and experiences with migrant care workers and included the following:

- Workforce profile
- Experience of hiring Irish care workers
- Advantages and challenges of employing migrant carers
- Experience with government regulations
- Impact of hiring migrant carers on quality of care

Telephone interviews were conducted with 16 employers to elicit more in-depth information on the topics of interest. These participants were selected from the survey respondents and were representative of the full range of employer organisations.

Migrant Care Workers and Older Adult Care in Ireland

It is helpful to provide a context for migrant care workers in the older adult care sector; both in terms of the proportion of foreign carers caring for older people in Ireland and the primary determinants of demand for this migrant labour force.

Just under a third (31.6 per cent) of all care workers in the organisations surveyed are foreign nationals, which compares to 16 per cent in the general health and social care sector and 15 per cent in Ireland's overall labour force (CSO 2006). The largest proportion of migrant care workers (46 per cent) are in home care organisations (see Fig. 1). Private nursing homes, which constitute the primary source of long-stay care beds in Ireland, employ the second largest proportion (37 per cent). The lowest proportion of migrant carers is in public long-stay facilities (14 per cent). Aside from home care organisations, there is a larger proportion of registered nurses (39 per cent) than care assistants (27 per cent), indicating that labour migration into the sector is primarily of a high-skilled nature. India was ranked as the primary source country for registered nurses by employers, followed by the Philippines. This reflects the Irish Nursing Board register and the ascendancy of India over the

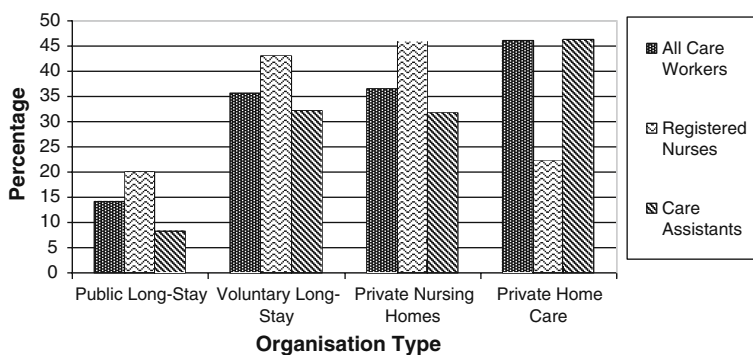


Fig. 1 Proportion of all care workers, registered nurses and care assistants who are migrants by organisation type. Note: Public Long-Stay = extended care units, welfare homes, district hospitals and community hospitals. Voluntary Long-Stay = voluntary geriatric hospital and voluntary geriatric home. All other categories as listed. Source: Authors' employer survey

Philippines as the primary source of nurses in recent years (5,466 versus 4,091—stock figures March 2008). Poland was ranked as the primary supplier of migrant care assistants, followed again by the Philippines.

Multiple factors contribute to the construction of demand for migrant care workers (including global ageing patterns), but given the scope of this paper only the key determinants of current employer demand for migrant carers in the Irish context are described. Difficulty in employing Irish carers was the principal reason for the high proportion of migrant workers in the older adult care sector. Almost 80 per cent of employers surveyed reported having difficulty in employing Irish registered nurses, while 44 per cent stated that they had difficulty in employing Irish care assistants.

There hasn't been availability of a local resource and in many cases they [migrant carers] are the only applicants for the job... They are the current source of staff that is available for employment really.

(Source: director of nursing—public long-stay extended care unit facility—interview Z009)

Difficulty in employing Irish carers was directly related to the proportion of foreign carers across organisation types. For example, public long-stay facilities reported the least difficulty in hiring Irish carers and reported employing the lowest proportion of migrant care workers. In contrast, private nursing homes expressed the most difficulty in hiring Irish nurses and employed the largest proportion of foreign nurses.

The second determinant concerned employers' appreciation for migrant carers' 'work ethic', which appeared to contribute to a sustained demand for the foreign workforce. A number of employers viewed migrant carers as a more reliable workforce, who had very little sick leave and absenteeism and who were willing to work full-time and shift hours.

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.

(Source: proprietor of private nursing home—interview 004)

It is important to recognise that concepts such as 'work ethic' and 'willingness to work' may be the product of feelings of obligation and lack of choice on the part of migrant carers, and an employer power advantage (Phillipson 2007). That said, the strength of these associations was robust across care settings and the public and private sector in this research, with similar findings documented in other studies (Stiell and England 1999; Loveband 2004; McGregor 2007).

Practice Issues for Migrant Care Provision

A number of practice issues arose from discussions with migrant carers themselves, and with employers and older adults. In effect these represent the key concerns about the use of foreign care workers to deliver care for older people and are inextricably linked to the perceived impact of migrant carers on the quality of care. Although a detailed discussion of each of these issues is not

the focus of this paper, an overview of the central problems pertaining to each practice area is presented below.

While a number of employers and older people spoke highly of the family orientated value system of some migrant carers, there were concerns around cultural understanding. Sixty eight per cent of employers felt that poor knowledge of Irish culture was a challenge in employing migrant carers. It was suggested that the absence of a shared cultural outlook may hamper the caring relationship and undermine person-centred care. Even though research in this area is limited, a number of authors support these findings (Xu 2007a; Brush et al. 2004; Johnstone and Kanitsaki 2008). Cultural differences were also apparent in the approaches to older adult care. Migrant care workers were thought not always to grasp the need for social care in addition to clinical care. As a result maintaining a person-centred approach became more difficult.

For a patient-centred approach to care you have to know where the patient is coming from, you have to know the culture of the patient. Irish workers find that difficult not to mind migrant workers...Promoting evidence-based person-centred care for older people is a huge challenge in itself and bringing migrant workers into it adds to that challenge enormously.
(Source: director of nursing—public long-stay extended care unit facility—interview X001)

Research has also shown the need for orientation to host nation care systems (Xu 2006, 2007b). In part, and especially for migrant nurses, employers attributed differences in approaches to carers being recruited from acute settings, in countries with predominantly informal systems of older adult care. Dyer et al. (2008) showed that foreign carers have difficulty in adjusting to formalised care approaches when informal structures are used in their home country.

Language and communication emerged as a significant challenge for all parties, with Irish regional accents and colloquialisms serving to exacerbate any difficulties even further. Proficiency in communication has been found to be central to the delivery of person-centred and high quality care (Xu 2007b, 2008; Johnstone and Kanitsaki 2008; Brush et al. 2004; Tuohy 2002). All migrant care workers, regardless of nationality and age, spoke about the necessity for adequate communication in their jobs and the barriers that can arise from poor language proficiency in everyday routines. This was true even for those participants from countries that are often considered to be bilingual.

It's like we were talking to the residents with the dictionary and the patients were just waiting you know while you check with the book, [you know.]
(Source: female registered nurse from the Philippines—interview 09)

Sixty-five per cent of employers surveyed stated that language proficiency was a primary challenge in hiring migrant carers. Employers in telephone interviews reinforced the issues that are involved.

I think communication skills are the biggest concern I would have. Because they [migrant carers] speak too low, the residents are half deaf and they're nervous when they come in and I think the communication really would be the major thing.
(Source: proprietor of private nursing home—interview X002)

The older adult focus group participants believed that language and communication was fundamental to the quality of provision. Aside from the core requirement to understand the needs of an older person, the importance of routine conversation and the social aspect of communication in caring for older people were also highlighted.

For a number of migrant carers, discrimination featured as a part of their work experiences. Selective recruitment, selective rostering, work team isolation, increased workloads (perpetrated by employers and other staff) and favouritism were some of the discriminatory behaviours (perpetrated by employers, other staff and older people and their families). These forms of discrimination have been documented within the general labour market (Carlsson and Rooth 2007; Dodson and Zincavage 2007; Anderson and Rogaly 2005) and within older adult care (Berdes and Eckert 2001; Alexis et al. 2007; Cuban 2008). Visible minorities, and particularly interviewees from African countries, were more likely to suffer discrimination.

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.'

(Source: female care assistant from Zimbabwe—interview 03)

Similar patterns of treatment have been noted in the international literature by Hagey et al. (2001) and Berdes and Eckert (2001). Other factors contributed to the construction of exploitative conditions. These included live-in home care settings, employment and immigration regulations (e.g. restrictions on labour mobility), and lack of knowledge of entitlements. A number of researchers have documented the role of such factors in the discrimination process (Piper 2004, Dyer et al. 2008). The impact of discriminatory behaviour on migrant carers was significant. Interviewees spoke about being shocked and distressed by their experiences and described the hurt that they felt when confronted by such behaviour—whether it was perpetrated by employers, other staff or older people and their families.

Because I just see it's pointing to one direction, and it hurts, it hurts so badly that...we're here not to... like live on the welfare... but I want to work... why do they not sit down and see I want to do it. But the people should please open up, accept us. We can do the same thing, we can do it. Just give us a chance.

(Source: female care assistant from Nigeria—interview 02)

Although rooted in policy and regulatory structures, immigration status had direct practice consequences for the participants in this research. Over half (56 per cent) of all employers surveyed experienced problems with government regulations for hiring migrant carers. Uncertainty caused by delays in visa processing, time-consuming paperwork, uncertain application criteria and the requirement to favour EEA nationals led employers to question the effectiveness of the current system.

I didn't fill out the application properly and they sent it back to me to tick a particular box. I sent it back to them again, and they sent it back again because I hadn't ticked a second box; why didn't they ask me the first time? They just make it so difficult for you.

(Source: proprietor of private nursing home—interview 022)

For migrant care workers, many of the issues mirrored those raised by employers. Restrictiveness, bureaucracy and delays associated with permit applications were the core problems. Comparable difficulties have been identified in other countries with similar regulatory structures, (Piper 2004, Ruhs and Anderson 2006, Dyer et al. 2008). Moving jobs through the permit system was a significant challenge, which became more serious when a carer was attempting to leave an exploitative situation.

Even though we are not treated well, we are scared to move. We are more afraid that we would be denied for the application for the work permit... We had to reapply for our work permit...it took me three appeals, because it was denied the first time.

(Source: female registered nurse from the Philippines—interview 04)

This finding is supported by studies in the literature (Asis et al. 2004) and by the findings of the other national studies on the '*role of migrant care workers in ageing societies*' research project, from which the articles in this special issue are drawn.

The majority of migrant carers felt that the rate of pay for older adult care was generally poor in Ireland and reflected the low priority given to the work. In many cases, particularly care assistants working in the private sector, interviewees received close to the minimum wage.

I think the first thing this job should be ...they should be paid a higher salary for this job...for example, I get nine euro [per hour], but I'm working 6 years already.

(Source: female care assistant from the Ukraine—interview 01)

Aside from the implications for the individual, the adverse effects of low-rates of pay on organisational dynamics, e.g. staff morale and employee turnover, were also noted.

They like the work here, only the salary—they are not giving increments, and they're fed up, that's why they are going.

(Source: female registered nurse from India—interview 016)

Distinctions across the public–private sector and work settings were evident. The standardised wage increments and salaries of the public sector were praised and were significant pull factors towards public employers. Nevertheless, some workers in public settings still felt that the remuneration was insufficient. The majority of participants did not consider pay and conditions to be only a problem for migrant carers. Interviewees spoke about the general discontent across all workers with the levels of pay in the older adult care sector.

I can't say that it's not fair because it's equal to everyone. So I can't say that it's not fair. If they do something you know, all are equal here, all of us are working the same hours, so I don't feel anything different.

(Source: male registered nurse from India—interview 015)

Implications for Quality of Care

The practice issues, although significant, are not unexpected with respect to care delivery by migrant workers. However, it is the implications of these issues for the

quality of care provided to older people that are of particular relevance. It is interesting in that regard that only nine per cent of employers said that employing migrant care workers has negatively influenced the care delivered by their organisations. With reference to Fig. 2, more than three times that proportion (33 per cent) thought that employing foreign carers had improved the quality of care, but the majority of respondents (58 per cent) stated that the quality of care had not changed. This was supported in the employer telephone interviews. Employers spoke about the education levels, professional training and the clinical skill sets of migrant carers and the positive impact of such attributes.

I feel that they have an awful lot to offer us. I wouldn't be afraid of having migrant care workers in this country at all. I think we have an awful lot to learn. Their work ethic you know...Like it's simple things. They have got skills like phlebotomy skills...they do IV...They would be likened to a CNS [clinical nursing specialist]. The people I am coming across are highly skilled.

(Source: director of nursing—private nursing home—interview Z040)

Employers recognised that migrant carers are now a fundamental element of older adult care in Ireland. With few labour market alternatives, there is a realisation of the reliance, and perhaps even dependency, on foreign carers to work in their organisations. This was succinctly articulated in the question raised by one employer.

Without migrant workers—who would look after older persons in care?

(Source: director of nursing—public long-stay extended care unit facility—interview Z001)

The nursing home residents were very positive in their descriptions of their experience with their migrant carers and the level of care they received. Participants described the migrant carers as being “*first class*” and stated that they “*listen to anything you have to say and are very anxious to please you.*” The residents acknowledged the important role of the nursing home administration in ensuring that the carers were committed to caring for older people. In the case of the community dwellers, participants found it difficult to say, from their standpoint, whether the impact of migrant carers on the quality of care was positive or negative overall.

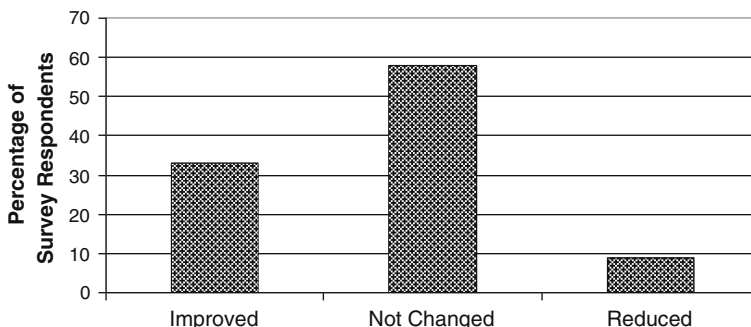


Fig. 2 Reported impact of hiring migrant carers on the quality of care. Source: Authors' employer survey

Nevertheless, as with employers, the community residents noted that without foreign national carers the quality of care would be much worse.

Without these migrant workers, we wouldn't be able to staff a lot of the places... we're happy we have the care.

(Source: focus group with community dwelling older adults)

Frequently, problems concerning migrant care workers and quality of care rested more on the supports, or lack thereof, for foreign workers and their employers, than on migrant carers' commitment or contribution to the sector. This was true for both employers and older people. It is in this light that the practice issues surrounding cultural understanding, language and communication, discrimination, immigration status and pay and conditions were viewed as threats to the sustainability of the migrant care workforce in the older adult care system.

Employers highlighted the fact that understandably foreign carers required additional time to adjust to Irish culture and to the health and social care system in Ireland. The absence of adequate support mechanisms for migrant carers in the sector intensified transition issues and increased pressure on Irish staff to support new migrant hires.

It was a learning process...The staff on the ground, the Irish workers were left...on the floor helping [migrant carers] to integrate into it and it was done very successfully. But with huge challenges and with huge extra pressure on the Irish nurses.

(Source: director of nursing—public long-stay extended care unit facility—interview X001)

The verification of qualifications, English proficiency assessment, and background checks were mentioned as areas that need further attention. Older adult focus group participants also suggested that a cultural induction programme would benefit migrant carers, both in terms of labour market and social integration, and their caring approach. The older participants thought that while efforts are required on the part of foreign nationals, the state has a responsibility to support the integration of migrant people.

If the state allows people in, they are accepting the responsibility by simply letting them in. If they are not taking the responsibility of helping them out, then they shouldn't let them in.

(Source: focus group with community dwelling older adults)

To compensate for the lack of official support, a number of employers had created their own orientation and training programmes for inducting migrant staff, including booklets of common phrases and colloquialisms. Employer interviewees suggested that a more structured orientation to Irish culture, the older adult health and social care system, person-centred care and to particular age-related conditions (e.g. dementia) should be introduced.

I think that anybody coming into this country needs to know the cultural differences. The cultural Ireland...They are coming to Ireland; they need to know the cultural differences, they need to know the nuances, they need to know the colloquialisms, you know.

(Source: director of nursing—private nursing home—interview Z040)

A recent review of an institutional abuse case in Ireland supported this call, recommending that appropriate levels of acculturation and gerontological training should be provided for all foreign-national staff caring for older people (Leas Cross Review 2006).

Employer interview participants were concerned that because of an overly bureaucratic employment permit system and because of the need to favour EEA nationals, they were not always able to hire the best person for the job. As a consequence, the efficiency and effectiveness of care delivery was thought to be compromised. Discrimination and pay and conditions can influence the quality of care in a similar way. Both discrimination and poor remuneration impact on job performance, as well as fostering low staff morale and higher turnover. In turn, the consequences of such turnover were said to impact directly on the quality of care provided to the residents.

Because so many staff is going from here every day...new people is coming... it will affect our residents' care, because they're used to some staff for 2 or 3 weeks, after that, all the staff is going.

(Source: female registered nurse from India—interview 016)

Older Adult Care—A Marginalised Sector

Broader concerns for the state of the older adult health and social care sector were expressed by all parties participating in this study and in particular by older people and employers. The impact of migrant care workers on the quality of care was rarely viewed in isolation from these sector-wide concerns, and for many, these problems directly underpinned the practice and support issues that are experienced in relation to foreign carers in the sector. Both older people and employers felt that older adult care in Ireland is under-resourced (in terms of financial and infrastructural investment), and is simply not prioritised.

This is reflected in the difficulty experienced by employers in attempting to hire and retain Irish carers in the sector. Rather than general labour shortages in health and social care, employers felt that there were insufficient numbers of indigenous people willing to work in older adult care. The employer survey and the employer telephone interviews indicate that there are several factors that discourage Irish carers from working in the sector and provide an explanation for why there is twice the proportion of migrant workers in older adult care than in both the general care sector and Ireland's overall labour market. These factors include pay and conditions; insufficient funding; poor career pathways and training; and a lack of prestige associated with caring for older people. Researchers have noted that such problems are generally present in older adult care in other countries and thus are not confined to Ireland (XU and Kwak 2005; Simonazzi 2009).

Smith and Mackintosh (2007) state that older adult care in the UK has long been disadvantaged relative to the other sectors of nursing and care provision. Through a historical analysis of nursing in the UK, (informed by an earlier generation of migrant Irish nurses), the authors demonstrate a 'pecking order' associated with the different care institutions and medically defined specialities. This hierarchy

reinforces divisions within care provision (across social class, gender, race and more recently immigration status), which in turn affirm the hierarchy of the specialities even more. Arising from the professionalisation of care in the 19th century, upper middle class women worked mainly in the acute illness sector, while working class women staffed poor law institutions and asylums for older people and the mentally and chronically ill. This distinction was reinforced through the associations of 'high tech' care with acute settings and 'routine and basic care' with long-stay institutions.

Although social class links are not as evident in today's care divisions, associations with low status and 'routine and basic care' still exist and underlie the disadvantage of the older adult care sector. Smith and Mackintosh (2007) also outlined how traditional charitable and care orientated sectors, such as care for older people, are often marginalised because of engrained associations with female social roles. Thus, even though gender was not apparent as a driver of discrimination for the individuals in this research, some sector wide issues may be a consequence of the lack of prioritisation given to such traditionally gendered professions by society and government.

The range of problems within older adult care in Ireland shows the complexity of the challenge facing the sector. The extent to which these problems are interrelated means that it is difficult to disentangle their significance and thus their influence over a person's decision to enter or leave a carer position. Nevertheless, it seems likely that they form the basis for at least some of the difficulty in hiring and retaining Irish carers and the increased reliance on migrant care workers. Excessive sick-leave, absenteeism and turnover have all been found to be related to inadequate employment conditions in the older adult care sector across other countries (Simonazzi 2009).

Kingma (2007) notes that recruiting migrant nurses, or carers, into a dysfunctional health system is not going to solve the problems of retention in the sector. In fact, evidence suggests that sector issues will reinforce the division between indigenous and immigrant carers (Smith and Mackintosh 2007). Migrant carers in this study identified how poor rates of pay across the sector can decrease staff morale and increase turnover for all workers. While the effects of insufficient remuneration are reasonably direct, the migrant care workforce is also likely to be increasingly influenced by the more subtle issues of poor career pathways and training, lack of prestige and the draw of other sectors. There needs to be recognition that many of the same issues that currently impact on the decision of Irish carers to enter or leave the older adult care sector are also likely to impact on migrant carers—if not now, then in the future.

Employers in this research wanted to see older adult care promoted and re-prioritised, both as a career and as an area for additional funding.

If somebody is going to get €10 or €12 down in [a retail shop] sitting at a counter...whereas they have to come in and be really really active in providing the most intimate care to people and dealing with the most difficult challenging behaviours, I think certainly pay and conditions has to be addressed. Certainly pay and conditions, career opportunities...to make the job a kind of worthy job. (Source: director of nursing—private nursing home—interview 053)

There was a general feeling that the importance currently placed on older adult care is not sufficient and a perception that considerable inequity exists in regard to the allocation of resources to the sector, relative to other areas. This was evident in the statement of one employer who highlighted the apparent reluctance to provide suitable levels of care to older people.

Lack of funding is horrendous really. If you and I had a heart attack tomorrow morning or a stroke we would get everything pumped at us, drugs, operations, surgeons, consultants. It would cost a quarter of a million. But to fund an elderly person seems to be a dirty word in this country... the fact that they were healthy for 80 years and cost nothing; now that they're coming into long-term care they are seen to be a problem.

(Source: proprietor of private nursing home—interview X002)

This was supported by the community-dwelling older adults, who demanded that a re-think of how we approach care for older people was necessary. It was felt that older adult care is not prioritised and often appears to be disregarded altogether.

I think older people are very low down... in the pecking order, in priorities I don't think we are prioritised... but at least we should be considered and I don't think that we are, at all.

(Source: focus group with community dwelling older adults)

In addition, older participants recognised that the issues surrounding migrant carers were often only highlighted by the inadequacies of the current system of care.

The problem was always there... but it's just exacerbated now with the people [migrant carers] coming.

(Source: focus group with community dwelling older adults)

Regulatory structures for older adult care were a matter for concern. Employers and migrant carers recognised the need not only to ensure high quality care, but to be vigilant that organisational structures and processes do not compromise the rights and entitlements of older care recipients. In effect, this again illustrates that there are two vulnerable groups of people at the centre of this research. In particular, without appropriate legislative systems in place for home care, many older participants felt that regardless of who was providing the care, older people's homes could become sites of maltreatment and neglect similar to some institutional settings.

We all know what happens in nursing homes... is this going to be replicated now in our own homes?

(Source: focus group with community dwelling older adults)

Of course, this lack of regulation also increases the vulnerability of migrant carers to exploitation within home care settings.

It is too early to determine if the new 'National Quality Standards for Residential Care Settings for Older People' will be a success, but it is hoped that these standards will address the previous regulatory deficiencies in institutional care and will soon be expanded to home care.

Concluding Remarks

There are significant practice challenges for migrant care workers in the Irish older adult care sector. However, as demonstrated in this paper, the central issues surrounding foreign national care workers in ageing societies inevitably lead to deeper concerns surrounding the state of the older adult care sector in Ireland. Migrant care workers, older people and employers in this research were concerned about the value that is placed on older adult care in the country. The commonality of these views show that even with the diversity of perspectives included in the research, there is a consensus of unease with respect to care provision for older people. This is reinforced by the substantial literature on the disadvantage of the sector presented in this paper.

In this regard, poor pay and conditions; under funding of the sector; poor career pathways; inadequate training structures; lack of prestige and deficient regulatory structures are symptomatic of a collective failure to prioritise older adult care; evidenced by the fact that Ireland spends less on older people than most other European countries (NESF 2005). On the basis of such findings the historically disadvantaged nature of older adult care in previous centuries, identified by Smith and Mackintosh (2007), appears to be very much prevalent in contemporary Ireland.

As noted in the introduction to this paper, although there has been substantial rhetoric regarding the need for person-centred care for older people, there has not been a definitive effort to apply this discourse to health and social care policy and practice. Commentators have noted that Irish age-related policy has been embedded within a distinctly ageist outlook—emphasising a homogenously dependent population and a reactive rather than preventative focus (NESC 2005). More worrying perhaps, is whether this is reflective of how society in Ireland sees the care of older people at a deeper level, beneath public discourse. Failing to prioritise care, or to invest in and value the structures and personnel who provide that care, effectively challenges our attitudes towards our older citizens.

The experiences of migrant care workers and the challenges that they face in caring for older people in Ireland must be framed within this context and within the context of the sector itself being marginalised. This paper illustrates that being employed in the disadvantaged older adult care sector intensifies the marginalisation of migrant care workers. Therefore, as opposed to the theoretical postulate of Peck (1989) it is not just the social division of foreign nationals outside the labour market that influence the employment experiences and opportunities of migrant carers, but the social division of care itself. While this is not to suggest that language and cultural issues, or discriminatory behaviour, are necessary by-products of an under-funded sector, such problems are exacerbated by the lack of resources, support structures and commitment to address the various challenges faced by migrant carers. Ultimately, this threatens the quality of care delivered to older people in Ireland. In this way, therefore, the well-being of older people and that of their migrant carers are inextricably linked. It would thus be worthwhile to consider this context when attempting to tackle these challenges and reform policy concerning migrant care workers caring for older people.

The new regulatory system for residential settings is an important watershed for the care of older people in Ireland. To a certain degree, the reforms should offer some protection to migrant carers—at least those in long-stay care settings. However, the continued absence of regulation for home care provision is a problem for both care users and care givers. What this research has shown is that there should be a focus on the particular requirements of migrant carers to ensure that they can not only provide high quality care, but that they are supported and protected within all care settings. Up to this point though, there has been an absence of an inter-sector, inter-agency and inter-departmental approach to the development of standards, policy and legislation for migrant carers caring for older people. To an extent, this may simply reflect the fact that apart from some cursory references in policy and guideline documents (e.g. Health Service Executive 2008; NCCRI/IHSMI 2002), this topic has received little or no public or political attention in Ireland. In order to address the challenges highlighted in this paper, a collaborative strategy is required involving all stakeholders that represent the intersection between older adult care and migrant workers.

The contribution of migrant carers to the ageing sector in Ireland is substantial and valued significantly by employers and older people alike. There are, however, a number of practice issues that exist for foreign national carers and these certainly place them at a disadvantage within the sector. The engrained problems in older adult care in Ireland means that the sector itself sustains, and even contributes to, these issues and, therefore, serves as a basis for cumulative disadvantage for migrant carers. When older people have had to endure fragmented, under-resourced and inequitable care provision, the value we place on their carers, represented through support, training, pay and protection, also comes under question.

This paper shows that in this context, it is impossible to separate the experiences of migrant care workers from that of the older people that they care for. Although, almost 75 per cent of participants in this study intended to remain in the sector, appropriate levels of support infrastructure must be provided if the migrant care workforce is to be a truly sustainable component of our older adult care system. While outside the scope of this paper, consideration also needs to be given to the impact of care worker emigration on source nations (in Ireland's case primarily India, the Philippines and Poland) and the consequences for the delivery of care to their older populations. Targeted investment for migrant carer training, education and orientation is needed in Ireland. More so though, larger scale reform and investment is required across the sector to improve the lives of migrant carers and the older people for whom they provide care.

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