Skilled Female Migrant Care Workers Negotiating the 4th Shift: Paperwork, Preparation, and Personal Expressiveness

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This article focuses on structural changes in organizational contexts in the care labour market in England and its relation to the recruitment of skilled migrant women from all parts of the globe, namely India and the Philippines. It targets female care workers in private care homes or agencies providing personal care assistance (dressing, bathing, chatting, feeding, cooking, helping to walk and move) to the elderly in their private homes, in private residential care homes, or in private nursing homes. Migrants comprise approximately 19% of all paid care workers in England, most of who are women. Public discourses on migrant care workers focus on their filling “occupational gaps” in the labour market rather than their expertise. Yet when they are praised, ethicized descriptions of them are rife in the media and their respectfulness to the elderly is attributed to their cultural attitudes. Rarely are their former degrees and qualifications mentioned as contributing factors for the high quality of care that the infirm elderly receive from them.

An Economic Social Research Council (ESRC) study of female migrant social care workers in England who were former nurses, midwives, and physical therapists in their former countries showed they effectively balanced the labour demanded by the modernized care industry in the occupation, of ‘care worker’; this included filling out reams of paperwork (like writing reports on clients), dealing with clients’ emotional needs (personal expressiveness such as chatting with them and listening) with attending many trainings (preparation, which includes topics on health and safety and inductions). Their abilities and willingness to fulfill these new mandates make them valuable human resources to employers in England’s modernized commercial care industry. Their hard work and commitment to care, in all of its forms, is exploited by an industry, which compensates them much less than their actual worth. While there identities as health care professionals is often acknowledged by clients, their medical expertise, is downgraded by the management of the private care home companies or agencies that employ them. The conditions of their labour (unsociable and on-call hours, low pay, no sick leave or over-time, and few promotional opportunities) do not match their high-level aptitudes, specializations, and care ethic.

In this study, many of the care workers who were former medical and health care professionals wondered if they had lost their skills and missed opportunities by not stepping directly into the nursing field in England. Furthermore, their contracts, which were determined by their recruitment agencies, embedded them into these jobs at the earliest stages, making it difficult to leave when they wanted, and through the new Points Based System, employers became their “sponsors” which bonded them further.

1 Allession Cangiano, Isabel Shutes, Sarah Spencer, George Leeson, Migrant care workers in ageing societies. Executive Summary. Compas, 2009
2 See Isabel Shutes study, Compas, Oxford, Migrant Health Care workers in ageing societies
http://www.compas.ox.ac.uk/fileadmin/files/pdfs/Migrant_Care_Workers/Health%20care%20workers%20article%20final.pdf
together. At the same time, they also adapted their expectations and attitudes to fit with industry standards, so as to adjust to their new occupations, without being frustrated and angry on a constant basis. In doing so, they focused on their commitment to working in the field of care and for elderly people who they saw as abandoned by their families and marginalized in society. Also, since many of these health professionals had not worked with the elderly previously they often found this population to be of interest medically, and became interested in gerontology for the first time, and aspired to work in nursing homes in the future. Yet nursing homes for migrants are often occupational ghettos.

Employers are well aware that migrant carers who are former health care professionals are proficient in, and, willing to do the extra hidden care work—which I refer to as: paperwork, preparation, and personal expressiveness and that they aim to advance themselves in their medical careers and have a professional commitment to care. Their juggling of care activities can be called, the 4th shift of labour. It builds on Arlie Hochschild’s 2nd shift, where women work for pay during the day and do cleaning and caring at night and Sharon Bolton’s 3rd shift, where women doubt their career decisions. This study suggests that skilled migrant care workers’ myriad skills (i.e. academic literacy) as well as their emotional labour, and engagement in care labour practices are important factors for why the industry has been successful in providing care to a population who might not receive it without them. Yet skilled migrants don’t simply reproduce the industry’s disciplinary aims. Instead they negotiate the standards to produce ‘healthy spaces’. Their contributions, however, are overlooked and are under-appreciated.

**Paperwork**

Administrative work and the time to complete it is part of Britain’s 21st century audit culture, which has penetrated the care industry as many activities now need recording (in logs and reports). Mature British-born workers find this task demanding and stressful, and are leaving the field. Skilled migrant care workers, however, engage in technical writing with ease, as this study found, even adding information to the paperwork and ensuring it is accurate. Although it is labour-intensive, the paperwork became an opportunity for them to check their colleagues’ care and certify their own. The writing aspects of the care work reminded them of their former professions, where recording and documentation of client conditions was important. On the other hand, employers have the opportunity to make their work more difficult by forcing them to duplicate every single act of a care interaction in log books. These demands caused stress because it added to their workload and made them feel scrutinized.

**Preparation**

Care training has historically focused on managerial procedures, not factoring skilled migrants’ expert skills and knowledge. Trainings have become an important requirement under the new legislation, The Care Standards Act of 2000, which force

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employers to train employees for National Vocational Qualifications and offer trainings without raising wages. Companies can advertise as having a ‘professional’ workforce who study on his or her own time. This study found that the migrant social care workers easily took and passed exams and others, and requested more specialist trainings including palliative care, dementia, and sight and hearing problems. But for those carers who were recruited as “students” ; hired on limited term contracts and for thousands of pounds (when it is often offered for a low price or free in workplaces) they would take trainings, which were vocational rather than professional, and which were not marketable. In several cases, training agencies did not contact students, or have assessors, like they promised. Several closed down and then wrongly accused the students of not paying and submitted their names to the UK Border Agency, which effectively makes the students “illegal.”

**Personal Expressiveness: Emotional Work**
Paid care work is time and labour-intensive, and involves emotional work. Clients have a range of demands that the carers are expected to fulfill by their companies, from chatting and comforting to feeding, toileting, and bathing in addition to using medical equipment such as hoists for lifting them. The carer is like a surrogate family member who is expected to take on all of these roles, while also, anticipating more needs on a constant basis and guarding them against possible safety and health dangers. There are many hidden skills and behaviors that are required for this position, while wages hover at the minimum. Skilled migrants were able to provide emotional labour under time constraints without complaint, and withstood complex encounters with clients and negotiated with them. Much this work was subsumed under the gender contract (care work as ‘women’s work’), which many of the carers embraced, but they *also* saw themselves as competent health care professionals with upscale dispositions and competencies to care for the elderly.

**Conclusion**
Complex, selective conditions for workers are now demanded in England’s social care industry. These conditions are interconnected, and imply overloading of responsibilities and behaviour to mould. Skilled female migrants, with their professional health care knowledge and identities, skills and expertise, and their participation in skilled migration care chains, can fulfill these new requirements of the industry. However, they are not recruited because of these traits, but because they are a cost-efficient solution to regulatory and business demands.

Systematic interventions are needed to assist this group to advance. Firstly, work conditions need to change, especially salaries and promotion opportunities. Although unions have tried to penetrate the private care industry and have made some changes, progress is still slow. Secondly, professional and adaptation opportunities need to be available so that this group can aspire towards their goals as health care professionals. Currently the Nurse Midwifery Council has raised the score of the International English Language Test system, making it difficult to pass. New standards should be applied that are realistic. Thirdly, advocacy efforts should be increased to draw more attention to the deskilling phenomenon affecting migrant women globally and the brain waste it generates.