

The Role of Migrant Care Workers in Ageing Societies: Context and Experiences in Ireland

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*“When older people...
have had to endure fragmented,
under resourced and inequitable
care provision, the value we
place on their care givers...
also comes under question.”*

Background

This report explores the role and potential of migrant care workers in caring for older people in Ireland. The proportion of migrant carers caring for Irish older people has increased over recent years, reflecting a broader global trend in care worker migration and thus, a highly competitive global market for migrant carers.

However, there has been relatively little effort to understand the implications of these cultural changes in our care workforce. Such a gap in current knowledge means that there are questions around the demand for migrant carers in older adult care, the impact of the current economic decline on future demand, the experiences of migrant carers caring for older people and the impact of employing migrant carers on the well-being of older people. Without an understanding of the various factors that can influence the sustainability of the migrant care workforce in Ireland, our ability to identify and address regulatory and practice issues in the sector and our capacity for workforce policy and planning may be fundamentally undermined.

Furthermore, migrant workers and older people are often considered to be marginalised sections of the population. The issue from a policy and regulatory standpoint is to ensure that the entitlements of both older people and migrant carers are upheld, thereby maintaining the human and civil rights of both groups. In essence, if this symmetry does not exist then there is likely to be serious implications for the quality of older adult care in Ireland and the future of the sector. Although this report only focuses on Ireland, the research was completed as a part of a larger collaborative cross-national project looking at Ireland, the UK, the US and Canada.

Aim and Objectives

The aim of the research is to explore the implications of the recruitment of migrant carers for the delivery of health and social care to older people, for the living and working conditions of the migrant carers, and for immigration, integration and older adult care policies. In the context of this report 'migrant carers' refers to foreign national citizens working as registered nurses or care assistants in Ireland. The research involves the following set of objectives:

- 1 Analyse factors that determine the current and future demand for migrant carers in the health and social care of older people in Ireland.
- 2 Examine the migration and work experiences of care workers: the means and motivation for migration, the role of recruitment agencies, choice of employment and working life.
- 3 Explore the current and future role of migrant carers in health and social care and their impact on the structure of care and independent living of older people.
- 4 Investigate the impact of employing migrant care workers on older people, their families, the quality of care and the carer-care recipient relationship.
- 5 Explore the most effective and ethical policies to regulate the admission, employment and integration of registered nurses and care assistants in the older adult care sector.

Methodology

Existing national and official data on this topic is limited in Ireland. Information on nationality has only been collected recently and typically applies on an aggregate basis rather than on a sector specific level. As a result, this report relies on primary data collected from migrant care workers, older adult care users and employers through a set of qualitative and quantitative research instruments. Stakeholder focus groups and expert papers were also used to provide a background and context for the work. The details of all methodological components are outlined below.

Stakeholder Focus Group (background component 1): A focus group was organised with national voluntary and statutory stakeholders from both the migrant worker and ageing sectors. The purpose of the discussions was to draw on the experiences of the participants to identify the key issues affecting migrant care workers in the ageing sectors.

Expert Papers (background component 2): Three expert papers provide the context for the research in this report. The first describes the older adult health and social care sector in Ireland. The second explores migration trends and public policy for immigration in Ireland and the third analyses the broad determinants of demand for migrant care workers and presents projections for the future.

Migrant Care Workers: Individual semi-structured interviews were conducted with 34 migrant carers to gather their experiences, opinions and future intentions concerning the older adult health and social care sector. A focus group was organised with a further six migrant carers to explore similar topics in a group setting. The participants were recruited from several sources (e.g. migrant and community organisations and health and social care networks) across Galway, Cork and Dublin.

Employers: A postal survey was distributed to all long-stay care institutions in Ireland and to all known home care organisations in the country (N=570). The purpose of the survey was to gather both quantitative and qualitative information on reasons for hiring, and experiences with, migrant care workers. More than 50% of surveys were returned. Follow-up telephone interviews were conducted with 16 employers to elicit more in-depth information regarding their experiences with migrant care workers. The participants were selected from the survey respondents and were representative of a range of employer organisations and geographical locations.

Older Adult Focus Group Discussions: Three focus groups were organised with older adults to gather their opinions of and experiences with migrant care workers in the health and social care sector. The focus groups also explored the participants' thoughts on Ireland as a multicultural society, their own preferences for care, their future plans for care provision and their perceptions of negative and positive aspects of migrant care workers caring for older people. The focus group participants included prospective users of care, who lived in the community, and current users of care, who were resident in a nursing home.



Key Findings

There has been a significant increase in the number of migrant nurses and care assistants in the older adult health and social care sector in recent years. While the economic decline may exert downward pressure on the demand and supply of foreign national carers in the short term, migrant carers will continue to be a feature of older adult care in Ireland in both the medium and longer term. For that reason, this report is necessary and timely to inform future policy and practice. The conclusions of the report, the key points of which are outlined below, illustrate that in the context of the older adult health and social care sector, it is impossible to separate the fate of migrant care workers from that of the older people under their care.

Demand and Supply

The projected need for migrant care workers into the future is likely to be significant. It is unlikely that the current economic decline will be sufficient to reverse the long-term trend of increased reliance on migrant care workers in the health and social care system in Ireland. The strongest determinant of the demand for foreign national care workers is the difficulty in hiring and retaining Irish carers, especially registered nurses. This difficulty appears to be linked to negative perceptions of caring for older people, lack of career pathways, general under funding in the sector and a reluctance to work shift hours.

Migrant care workers make up almost a third of all care workers in the various care settings responding to this survey. Migrant carers were represented in all organisation types (home care and institutional) with the largest proportion in private home care and private long-stay care settings. Overall, there is a higher proportion of migrant registered nurses than care assistants in the sector. India, followed by the Philippines, is the primary source country for nurses, whereas Poland, followed again by the Philippines, is the primary source country for care assistants.

The primary reason for migrant carers entering older adult care is linked to opportunities for employment, although for some individuals the decision to remain in the sector was linked to an attachment to caring for older people. Almost 75% of participants interviewed intended to stay in the older adult care sector. Informal networks featured strongly as pathways to employment for migrant carers. However, 40% of employers used recruitment agencies to employ migrant care workers – predominately for nurses. While reducing paperwork was considered to be the main advantage of using recruitment agencies, issues of post-hire support and recruited staff quality were also highlighted.

Migrant Workers as Carers

The caring relationship between migrant carers and older people is complex and multifaceted. Care provision is both emotionally and physically demanding, which involves dealing with multiple transitions, losses and degenerative and debilitating conditions. Feelings of making a difference, emotional attachment, friendship and personal growth are all positive aspects of caring for older people, as expressed by migrant workers themselves. Care for older people extends, therefore, beyond simple service provision.

Although not characteristic of the experiences of all migrant carers, discrimination was a significant issue for some carers. The drivers of discrimination included those factors that contributed to the construction of exploitative or discriminatory conditions (e.g. employment and immigration regulations and private home settings) and issues around race and socially constructed images pertaining to cultural identity. However, it can be difficult sometimes to separate genuine personal care preferences of older people from latent feelings

of prejudice and discrimination. Consideration must be given to such sensitivities for a balanced care environment. In many instances though, issues around the acceptance of migrant carers by older people and staff were concentrated in the initial period of employment and dissipated over time.

Migrant workers did not identify wage discrimination as a serious problem within the sector. This was mainly because poor pay was perceived as a problem generally in the older adult care sector and was not specific to migrant carers. However, there was evidence that poor rates of remuneration did lead to low morale, higher rates of turnover and ultimately poorer quality of care delivery among all carers.

Older People and Migrant Carers: Perceptions and Experiences

Language and communication was a significant challenge for migrant carers, employers and older people. Problems in language proficiency was a central issue in the caring relationship between migrant care workers and older people, but was exacerbated by regional accents, colloquialisms and telephone contact. Communication challenges, therefore underpinned many of the other issues concerning labour market and social integration. Poor knowledge of Irish culture among migrant carers was also identified as an issue, undermining the sense of shared cultural experience for the older person. By contrast, similar religious beliefs facilitated a greater acceptance of migrant carers by older people. Differences in cultural approaches to care of older people were also evident, particularly in relation to person-centred care. This was in part due to carers being sourced from acute sectors in countries with primarily informal systems of older adult care, leading to them having little experience of care within long-stay settings.

Parallels were drawn between the value systems of some nationalities and what was perceived to be our own family-centred approach to caring for older people in the past. A shared experience with migrant workers with respect to emigration was also evident among some older people who themselves, or their families, had emigrated to find work. There was a strong sense of admiration and respect for labour migrants who saved money to support family and to achieve a better life. While some older participants felt that this shared experience would help Irish people accept migrant carers, others felt that Ireland's historical lack of experience with other cultures would serve as a major barrier to accepting foreign national carers.

The majority of employers surveyed stated that the quality of care did not change with the employment of migrant care workers; quality was at the very least maintained and sometimes improved. There was consensus, however, that education, training and orientation was necessary to ensure that migrant care workers could deliver appropriate person-centred care. Both employers and older people agreed that without the migrant workforce there would be a shortage of care staff to care for older people in Ireland and that many of the current issues around migrant carers caring for older people reflected broader problems in the older adult health and social care sector concerning funding and prioritisation. For example, training for person-centred care provision is necessary for all care providers and not just migrant carers.

The majority of employers surveyed felt that the older adult health and social care sector in Ireland is under resourced and under funded. A number of migrant carers questioned the value that is placed on care for older people in Ireland, when the rates of pay for such a demanding role are generally so poor. Older people did not believe that they are being given the priority they deserve, whether in respect of social valuation or health and social care provision.

Policy and Regulations

The immigration and employment regulations had a significant impact across both work and social domains. The primary issues for employers included delays in processing applications, time-consuming paperwork and uncertain application criteria. Similarly, restrictiveness, bureaucracy, frustration and delays in processing characterised the experiences of many migrant carers with regard to immigration and employment regulations. The regulatory system appeared to reduce the opportunities for employment and increased the vulnerability of people to exploitation. The short-term duration of the work permit system may also threaten the continuity of care for older people. Issues surrounding long-term residency and family reunification also impact on the lives of migrant carers and resulted in feelings of uncertainty with respect to staying in Ireland. That said, the majority of migrant carers intended to be still living in Ireland in five years time.

The conceptualisation of skill level in care giving needs to be reassessed – particularly for care assistants. Being a good carer requires a person to be compassionate and kind, as well as having the required professional qualifications. Therefore, personal care should not be conceived as low-skilled given the requirements necessary to deliver person-centred care. The current immigration channels for care workers should be examined to take account of a recalibration of perceived skill sets for caring.

The regulation of older adult care in Ireland has been less than satisfactory in the past. The implementation of the new ‘National Quality Standards for Residential Care Settings for Older People in Ireland’ will improve matters in that regard. However, the continued absence of regulation in the private home care sector means that older people may be at risk in their own homes. Minimum standards of training should be set for all care positions and across all settings in the older adult health and social care sector.

The older adult health and social care sector in Ireland is disadvantaged and marginalised. This exacerbates the problems for migrant carers caring for older people. There is significant overlap in relation to legislative standards, policy and practice for the protection of older people and migrant carers. Current policy and regulatory development does not reflect this overlap, remaining largely separate and disjointed. If this lack of integration continues to be a feature of the sector, the issues and challenges highlighted in this report will become more serious and the opportunities for the development and sustainability of the migrant labour force in the care of older people will become fewer.

Recommendations

There are eight recommendations arising from this report. These are as follows:

- 1 Pathways for greater person-centred care for older people that acknowledge the role of migrant carers must be formulated and implemented as part of the promised National Strategy for Older People.
- 2 The racial and cultural differences of care providers and recipients of care must be respected within domestic and long-stay care settings. Older residents, their families and the public need to be assisted in adapting to changes in the ethnic and cultural mix of care staff taking place within care organisations.
- 3 Increased resources and support structures for education, training, orientation and integration should be introduced for migrant carers and Irish staff to cope with multicultural care environments.
- 4 Appropriate structures for the reporting of racial abuse and labour exploitation should be put in place at organisational, regional and national levels.

- 5 The new system of registration and inspection for residential care settings must be extended to home care settings.
- 6 Information provision on migrant's rights and entitlements should be improved, particularly with respect to employment and equality regulations.
- 7 A more coordinated comprehensive approach to policy development for migrant workers is necessary to address issues around long-term residency, family reunification, permit system efficiency and the conceptualisation of care skill level.
- 8 Significant public investment in older adult care is required to tackle the disadvantage inherent in the sector, thereby enhancing the experience of care providers and care users alike. The issues affecting migrant carers and older care recipients are intertwined and thus it is necessary to focus on the overlapping rights and entitlements of both groups in addressing problems in the sector.

Introduction



“Central to the provision of older adult care are issues surrounding who we entrust to look after our older citizens.”



Background and Justification

The care of our older people in Ireland has always been a delicate subject, provocative in the sensitivities that it unearths. On the one hand, the concern for the welfare of older family members and friends dominate familial and social discourse. On the other, questions surrounding the effectiveness of how we address the needs of these individuals drive public advocacy and political debate. Central to the provision of older adult care are issues surrounding who we entrust to look after our older citizens. With the traditional family model of care giving slowly eroding in Ireland, it is now more important than ever that there is a stable and well skilled labour force to care for our older people.

The high labour turnover rates seen at the start of this decade in the care sector, (McCarthy et al. 2002) coupled with a gradual ageing of the population (CSO, 2006^a) has meant that the older adult care workforce has undergone a demographic and cultural transformation. The increase in the number of migrant health and social care workers in the sector has become increasingly evident over recent years. While detailed workforce data is unavailable at an official level, the prevalence of foreign national carers in the long-stay sector is marked by the fact that 49% of nursing staff and 36% of all staff in private nursing homes are from another country (Annual Private Nursing Home Survey 2007). The public sector has also seen an increase in migrant care workers, as have agencies providing market-based home care services.

The immigration of care workers is not confined to Ireland. There has long been an established tradition of health and social care worker migration from developing countries to western developed nations (Pittman et al. 2007; Lorenzo et al. 2007; Khadria 2007). The US, Canada and the UK, along with some of our other EU-15 counterparts, have been acknowledged as significant host countries. Although the nature of care worker migration differs across these nations, it is for the most part a function of high levels of demand for health and social care personnel - particularly those with professional qualifications. The extent of the demand has meant that many host countries are now reliant on migrant workers to bolster their care workforce and increase their care delivery capacity (Buchan 2007^a). In some cases, the dependency on migrant carers is so great, that current stocks and future inflows of foreign nationals are factored into workforce planning in the health and social care sector. The market for migrant care workers has thus become globalised, with competition between rival nations for the highest quality workers (Pittman et al. 2007).

Many host countries possess a far longer history of immigration than we do in Ireland. In some cases, receiving nations have an established relationship (formal and informal) with a number of source countries for the migration of care workers. By comparison, Ireland has only limited experience in managing labour immigration and in coping with issues around labour market integration for foreign workers. The influx of migrants into Ireland is relatively recent and our traditional role is that of a sending rather than receiving country (Barrett 2005; NESC 2006). This may place us at a disadvantage when attempting to attract and retain migrant care workers. In terms of wider Irish society, up to recently our population could be considered homogenous with respect to cultural, racial and religious characteristics. Our inexperience in dealing with other ethnic groups may pose a challenge as we move towards a fully integrated society. Conversely though, it is precisely our history of outward migration that may make integration easier, particularly for migrant carers of older people. The experiences of our older emigrant generations may parallel those of the migrant carers who now care for them.

There is a limited international literature on migrant care workers which becomes even more restricted when focusing just on older adult care provision. In the Irish context a comprehensive investigation of the role of migrant health and social care workers caring for older people has been largely absent from the literature. As highlighted in the National Intercultural Health Strategy 2007-2012 published by the Health Service Executive

(HSE), little is known about migrant carers of older persons in Ireland. With such a gap in current knowledge, high level questions around the intersection between ageing and migratory patterns remain unexplored. On a practical level, there are a series of factors that can impact on the sustainability of this care workforce and the quality of the caring relationship involving the carer, employer and older adult recipient.

The determinants of demand for migrant care workers in the older adult care sector are likely to be multi-dimensional. While simple need will undoubtedly play a role, the extent that other variables contribute to the constructions of demand is unclear. Moreover, the effect of the current economic decline on the future demand for migrant carer workers is not known to any degree of certainty. From a more micro perspective, the experiences of migrant carers working in the older adult care sector in Ireland have not been extensively investigated. As a result there is little information on the proportion of foreign national carers in the sector, the impact of employing migrant carers on workplace relations, the commitment and motivation of migrant carers to care for older people, their experiences of integration in Irish society and their intentions for the future.

Knowledge of the employer's viewpoint on hiring migrant carers is also deficient. Experiences in recruiting and hiring migrant carers for older adult care and thus the advantages and challenges of employing foreign national carers are unknown. Perhaps of most significance though, is the fact that the impact of the migrant carer workforce on the well-being of older people has not been explored. Given the importance of a strong relationship between carer and care recipient, issues such as language and culture may influence the nature of the interaction between migrant carers and older people. Ultimately, there are questions around the effect that employing migrant carers has on the quality of care that is being provided to Irish older people.

The complexity of this topic is in part illustrated by the cross-sector, cross-institutional, and cross-departmental context within which migrant carers provide care for older people. The intricacies, sensitivities and social expectations wrapped up in our personal and public constructions of care of older people only serve to complicate things further. It is unclear if the existing regulatory and legislative structures that span ageing, migration and employment domains are sufficient to address such a set of dynamics. Because migrant workers and older people are considered to be often marginalised, it is important to have structures in place that protect against any potential disadvantage that these cohorts may experience. The difficulty from a policy and regulatory standpoint is whether or not the entitlements of both older people and migrant carers can be upheld, without compromising the human and civil rights of either group. If this symmetry does not exist then there is likely to be serious implications for the quality of older adult care in Ireland and the future of the sector.

Without fully understanding the factors that impact on the migrant care workforce in Ireland, our capacity for workforce planning and our ability to identify and address issues in the sector are fundamentally undermined. Consequently, this report documents research into the role and potential of migrant health and social care workers in the older adult care sector in Ireland. While the report focuses solely on Ireland, this research is a part of a larger collaborative cross-national project focusing on Ireland, the UK, the US and Canada, and involves the Irish Centre for Social Gerontology (National University of Ireland Galway), the Centre on Migration Policy & Society – cross-national project coordinator - (University of Oxford), the Oxford Institute of Ageing (University of Oxford), the Institute for the Study of International Migration (Georgetown University) and the Community Health Research Unit (University of Ottawa). The research was conducted between Spring 2007 and Spring 2009.



Report Aim and Objective

The aim of the research is to explore the implications of the recruitment of migrant carers for the delivery of health and social care to older people, for the living and working conditions of the migrant carers, and for immigration and integration policies. In the context of this report ‘migrant carers’ refer to foreign national¹ citizens working as registered nurses or care assistants in Ireland. The research involves the following set of objectives.

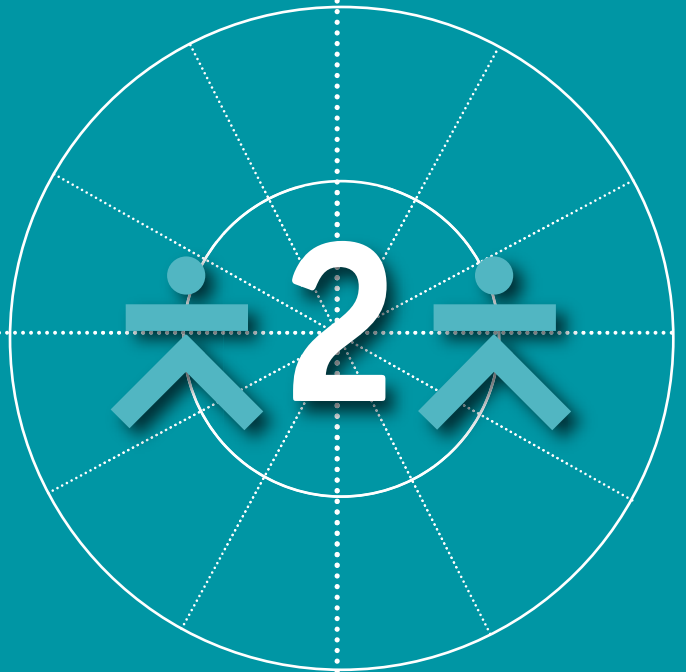
- 1 Analyse factors that determine the current and future demand for migrant carers in the health and social care of older people in Ireland.
- 2 Examine the migration and work experiences of care workers: the means and motivation for migration, the role of recruitment agencies, choice of employment and working life.
- 3 Explore the current and future role of migrant carers in health and social care and their impact on the structure of care and independent living of older people.
- 4 Investigate the impact of employing migrant care workers on older people, their families, the quality of care and the carer-care recipient relationship.
- 5 Explore the most effective and ethical policies to regulate the admission, employment and integration of registered nurses and care assistants in the older adult care sector.

Structure of the Report

Chapter 2 details the methodology followed in this research, outlining the approach and design, the background components of the research, and the qualitative and quantitative data collection techniques used. **Chapters 3, 4 and 5** provide a context for the research report. Chapter 3 gives a description of the central components of the older adult health and social care sector in Ireland. Chapter 4 focuses on migration trends and immigration public policy in Ireland, with particular reference to migrant workers in the health and social care sector. Chapter 5 presents projections for the changing age structure of the population and the future need for migrant carers. **Chapters 6, 7 and 8** present the findings of the research. Chapter 6 examines other factors that influence the current demand for and supply of migrant carers in the Irish older adult health and social care sector. Chapter 7 describes the experiences of migrant carers in the older adult health and social care sector and the various factors that impact on their working and living conditions. Chapter 8 looks at the impact of employing migrant carers, and related factors, on the lives of older people and the quality of care that is provided. **Chapter 9** presents the discussion of the findings with reference to international literature and national policy and legislation. **Chapter 10** describes the key conclusions of the research report with respect to demand and supply, migrant workers as carers, older people and migrant carers, and policy and regulations. Chapter 10 also outlines key recommendations arising from the research in the areas of practice, policy and regulation.

■ ¹ The categorisation of foreign national, as opposed to foreign born, is used in this report because much of the relevant data in Ireland is based on nationality. In addition, the categorisation of foreign born may include Irish citizens, who are not the focus of this report.

Methodology



*“Just under a third of all care workers
in the organisations surveyed are foreign nationals.”*

This chapter presents the methodology followed in this research study and outlines the approach and design, the background components of the research, and the qualitative and quantitative data collection techniques employed.

Approach and Design

The study protocol was established through a process of collaboration with the international project partners; the Centre on Migration Policy & Society (COMPAS), the Oxford Institute of Ageing (OIA), the Institute for the Study of International Migration (ISIM) and the Community Health Research Unit (CHRU). To achieve the aim and objectives of the research, the study was required to account for the central perspectives that can directly influence the role, experiences and effectiveness of migrant carers caring for older people. Consequently, three primary research strands were developed around (1) the migrant care worker, (2) the older adult care users and (3) the employers. This strategy allowed for a comprehensive exploration of the subject matter, facilitating a fully encompassing, but objective focus. It also permitted a more holistic view-point from which the resulting findings could be interpreted.

In developing each of the investigation strands, careful consideration had to be given to the cross-national comparative element of the research. The scope and scale of the pre-existing data and the accessibility and depth of information sources had to be assessed. Performing these preliminary feasibility assessments helped to construct a comparative strategy that optimised the effectiveness of the analysis. For example, relative to the other participating nations, and as noted by Rhus (2005), the data available for Ireland in this area is limited. As inward labour migration is a relatively new phenomenon, information on nationality has only been collected very recently, if at all. Additionally, the data that has been collected is typically at an aggregate level and is not always specific to the older adult health and social care sector. As a consequence of these restrictions, the usefulness of the existing information is significantly compromised, thus, a greater emphasis was placed on collecting primary data through the research instruments, thereby addressing the data disparities between the project countries.

Quantitative and qualitative techniques were used to gather the information as a means of including a macro and micro level of analysis within the study. Employing this mixed method approach enhances evidence-based research and provides a more structured channel for data analysis and interpretation. Combining these techniques as a part of the study design is also complimentary to the multidisciplinary scope of the research, which includes aspects of migration, gerontology and health and social care fields of study. A series of background components were included in the methodology to inform the design of the Irish data collection instruments, and to provide a contextual framework within which the resulting findings could be analysed. A description of these components will be first presented, followed by details on the methods of each of the three research strands.

Background Components

Expert Papers

Three expert papers were commissioned to provide the context and background to the role of migrant care workers in the older adult health and social care sector. The first paper was written by *Aoife Callan – Irish Centre for Social Gerontology*, and provides an overall ageing context for the research, describing the central components of the older adult health and social care sector in Ireland. This paper is Chapter 3 of the report. The second paper,

written by *Piaras Mac Éinrí - Migration Studies Unit, Department of Geography, University College Cork*, focuses on migration trends and immigration public policy in Ireland, with particular reference to migrant workers in the health and social care sector. This paper is Chapter 4 of the report. The third paper, written by *Alan Barrett - The Economic and Social Research Institute* and *Anna Rust - Irish Centre for Social Gerontology*, presents a socio-economic analysis of the older adult health and social care labour market and is Chapter 5 of the report. Determinants of demand are explored and projections for the future need of migrant care workers are presented in this chapter.

Stakeholder Focus Group

A focus group discussion was organised with national voluntary and statutory stakeholders from the health and social care, ageing, and migration sectors. The purpose of the focus group was to draw on the experiences of the participants to identify the key issues affecting migrant care workers in the health and social care sector. The focus group was conducted prior to the field research, so that the key issues could be addressed through the data collection instruments. Eight participants took part in the discussion, including representatives from the Department of Justice, Equality and Law Reform, the Department of Health and Children, the Health Service Executive, Nursing Homes Ireland, a private home care agency, the Immigrant Council of Ireland and the Migrant Rights Centre Ireland. A broad agenda was used to guide the discussion and to cover the following topics:

- Issues related to migrant workers entering Ireland
- Issues related to working and caring for older people in Ireland
- Issues related to migrants living in Ireland
- Issues related to Irish public policy on both migration and long-term care

Migrant Care Workers

The experiences, opinions and future intentions of 40 migrant care workers are included in this study. Thirty four participants took part in individual interviews and six people participated in a focus group. Interview and focus group participants were provided with information sheets, detailing the aim and methods of the research, so that informed consent could be obtained. Each participant received a shopping voucher as a token of appreciation for their contribution to the research.

Migrant Care Worker Interviews

Semi-structured in-depth interviews were used to gather detailed information on the perspectives of migrant carers working in the older adult health and social care sector. To reflect the national breakdown of the labour force in this sector, the recruitment process was structured to account for skill level (registered nurses and care assistants), the public, private and voluntary mix and institutional versus community settings of care provision. Consideration was also given to the primary source countries for migrant care workers. Although available data was inconclusive, employment permit and nurse registration statistics suggested that the Philippines, India, and countries from North and West Africa and Eastern Europe all featured strongly. Consequently, care workers from these regions were targeted. Recruitment took place across three HSE areas (Galway, Dublin and Cork) and while an element of snowball sampling was employed, the majority of participants were identified through ethnic community groups, organisations working with migrants and existing health and social care networks (e.g. public and private long-stay institutions and home care organisations). This strategy helped to avoid source and location bias in the sample. Attempts were also made to recruit undocumented workers in the older adult

health and social care sector through these sources, but this did not prove successful. Participants were required to be proficient in the English language, so as to fully understand the interview discussion and the study documentation.

An interview guide was used as a basis for the conversation, but was sufficiently flexible to allow the interviewee's personal narrative to be gathered. The topics of interest included the following:

- Decision to migrate and migration history
- Employment history
- Current care position
- Relations with older people, other staff and employer
- Work settings
- Impact of migrant status on experiences
- Coping with work and status demands

A short questionnaire on background profile was also administered after each interview. Items included questions on demography (e.g. age, marital status, number of dependents) and socio-economic (e.g. economic situation and money saved) information, length of residency in Ireland, immigration status, English proficiency, education, training, occupation and intentions for the future. The interviews were conducted in city centre locations in Galway, Dublin and Cork and on average lasted for one hour and ten minutes in total. All interviews were audio recorded.

Migrant Care Worker Focus Group

The focus group for migrant care workers was used to explore the themes emerging from the interviews within a group and collective forum. Participants were recruited using the same process and the same criteria for participation as the semi-structured interviews. The discussion agenda focused on the participants' experiences of and issues with (1) entering Ireland, (2) working and caring for older people in Ireland and (3) living in Ireland. Participants were also asked to fill out the background profile questionnaire used in the individual interviews. The discussion group lasted for one hour and 30 minutes and took place in Galway. The discussion was audio recorded.

Migrant Care Worker Participants

With reference to Table 2.1, 17 registered nurses (six from Galway; seven from Dublin; four from Cork) and 23 care assistants (twelve from Galway; five from Dublin; six from Cork) were involved in this research. Participants were aged from 20 years to 59 years and included five males and 35 females. Interviewees' residency in Ireland ranged from 1 month to 7 years with a group average of 4 years. Eleven nurses were from India, five nurses were from the Philippines and one was from Poland. Five care assistants were from the Philippines, five were from Nigeria, four were from the Ukraine, two from India, two from Poland, two from Lithuania and there was one care assistant each from Zimbabwe, Cameroon, and Latvia.

Four care assistants were employed by a public-long stay institution, one worked in a voluntary home/hospital, nine worked in a private nursing home, three worked as home carers employed by the HSE, two worked for a private home care organisation, three were employed directly as live-in carers by an older person's family and one care assistant was employed by the HSE as a home carer and also worked in a private nursing home. The majority of registered nurses were on a stamp 4, which allows the holder to work without a permit. These individuals would have received a stamp 4 after having worked and lived in Ireland for 5 years. The majority



of care assistants were either on a stamp 4 or a work permit. Seven of these participants would have received a stamp 4 after being granted refugee status, while two of them received a stamp 4 after having worked and lived in Ireland for 5 years. Care assistants on work permits would have entered Ireland prior to the salary restrictions on work permit applications introduced under the *Employment Permits Act 2006*. Chapter 4, which deals with migration policy, describes the immigration categorisations and status in more detail.

All registered nurses had worked in their home country as a nurse, whereas approximately 40% of care assistants had worked as carers in their home country. A fifth of the participants had completed second-level education, two thirds had completed third-level education, and 13% had completed third-level post-graduate studies. Eighty four per cent of all participants had a formal health and social care qualification. While all registered nurses had completed their training in their home country, the majority of care assistants completed their training in Ireland. Two-thirds of those interviewed were married, 10% were separated or divorced and just under a quarter were single. Almost 70% of participants had children. All of the children of five participants and some of the children of three participants were still living in the home country. Similarly, the spouses of four participants were still working and resident in their home country.

Table 2.1 Demographic profile of migrant care worker participants

	Registered Nurses	Care Assistants	Total
Gender			
Male	1	4	5
Female	16	19	35
Total			40
Source Countries			
India	11	2	13
Philippines	5	5	10
Nigeria	-	5	5
Other African	-	2	2
Ukraine	-	4	4
EU-Accession	1	5	6
Total			40
Work Setting			
Public long-stay care	4	4	8
Private long-stay care	13	9	22
Voluntary long-stay care	-	1	1
Public home care	-	3	3
Private home care	-	2	2
Direct-employ live-in	-	3	3
Across settings	-	1	1
Total			40
Current Immigration Status			
Work permit	-	9*	9
Green card/Work authorisation	2	-	2
Stamp 4	12	9	21
Work visa for nursing	2	-	2
EU citizen	1	5	6
Total			40

Source: Migrant care worker interview questionnaire.

NOTE:

Stamp 4 = Permission to work without employment permit, whereas

Stamp 1 = permission to work as long as an employment permit has been obtained.

* = care assistants on work permits would have entered Ireland prior to changes to the permits system made under *The Employment Permits Act 2006*. For a full description of immigration policy, categorisations and status see Chapter 4.

Migrant Care Worker Employers

Employers' Postal Survey

To acquire the perspective of employers of migrant care workers working with older people, a postal survey was distributed to 570 employers throughout Ireland. This sample included all private and public older adult long stay care facilities (e.g. extended care facilities, welfare homes, district hospitals, community hospitals, voluntary homes/hospitals, private nursing homes and acute hospitals with long-stay units) and 40 private home care organisations. Official data is not available for private home care organisations in Ireland and thus their exact number is difficult to ascertain. The sample used in this study is comprised of the 13 members of the Irish Private Home Care Association (at the time of survey distribution) and 27 organisations identified through literature and internet searches. With reference to *Appendix A*, the postal survey consisted of 20 items; the majority of questions followed a closed format, but seven items had an open element for additional respondent comments. The following topics were addressed in the survey:

- Organisation profile (e.g. type, size and location)
- Workforce profile (e.g. number and nationality of nurses and care assistants)
- Experience hiring and retaining Irish care workers
- Pathways of recruitment for migrant care workers (e.g. recruitment agencies)
- Advantages of employing migrant care workers
- Challenges of employing migrant care workers
- Experience with immigration regulations
- Impact of migrant care workers on quality of care

Respondents were given four weeks to complete and return the survey. Follow-up telephone calls were made to each organisation a week after survey distribution, to confirm receipt of the questionnaire, and again a week before the return deadline, to prompt a higher response. A second wave of surveys was distributed with a reminder letter to all employers who had not responded after the deadline had passed. The response rate to the survey was just over 50%, representing a return of 286 questionnaires. Table 2.2 displays the samples and response rates for each of the organisation types surveyed.

Table 2.2 Employer survey response rates by organisation type

Organisation Type	Sample Size	Response Rate
Public (HSE) Extended Care Facility	85	49%
Public (HSE) Welfare Home	33	64%
Acute Hospital with long-stay	6	67%
Voluntary Home, Hospital and Welfare Home	58	50%
Private Nursing Home	352	50%
Private Home Care Organisation	40	37%

Source: Employer survey



Employers' Telephone Interviews

Telephone interviews were conducted with 16 employers. The purpose of the interviews was to elicit more in-depth information regarding the employers' experiences with migrant care workers. The judgement sample was drawn from the postal survey respondents who agreed to participate in further discussion. Selection was based on staffing composition, the type of organisation, HSE area and responses made in the survey. Employers from eight private nursing homes, three public extended care facilities, two community hospitals, one voluntary hospital/home and two private home care organisations were interviewed. The interviews lasted for 30 minutes and were audio recorded. The discussion followed an informal structure based on a similar topic guide to that of the postal survey.

- Principle reasons for hiring migrant care workers
- Processes of recruitment
- Advantages of hiring migrant care workers
- Challenges of hiring migrant care workers
- Primary issues for the older adult care sector
- Recommendations for the future

Older Adult Focus Group Discussions

Three focus groups were organised with older adults to gather their opinions and experiences on migrant care workers in the health and social care sector. The first focus group was organised with ten community dwelling older adults, eight women and two men, who were recruited through existing social care and active retired networks in the Galway City region. These participants were considered prospective users of care; many of the participants had received treatment in acute settings and a number had knowledge of the long-term care system through relatives and friends.

The second and the third focus groups were conducted with residents in a private nursing home in the Cork County region. The nursing home was a 47-bed facility and was staffed by nine registered nurses and 22 care assistants. Six (67%) of the nurses were foreign national citizens, with five from India and one from Norway. Nine (41%) of the care assistants were foreign nationals, with the majority coming from the EU accession countries. Eight residents participated in the first of the focus group discussions and seven took part in the second. These participants were permanent residents with lengths of occupancy ranging from two weeks up to eight years. All participating residents were considered to be of low-dependency.

Both community dwelling and nursing home participants had to fulfil the following criteria for participation, which were derived from those used by Jobe, Ball, Marsiske, Rebok, Helmers & Kleinman (2001):

- 1 Sixty five years of age or over.
- 2 Not have experienced substantial cognitive decline.
- 3 Not have experienced substantial functional decline that would hinder participation.
- 4 Must not suffer from medical conditions that result in the above.
- 5 Must not suffer from severe sensory losses that would prevent them from participating.
- 6 Not possess communicative difficulties that would hinder participation in focus groups.

Prior to the discussions, information packs were provided to the community dwelling and nursing home participants through an intermediary (i.e. active retirement chairman for community dwellers and nursing home proprietor for nursing home residents). These documents outlined the background, aim and methods of the research. A request for participation was then made and informed consent was given. The focus group discussions lasted for one hour and were audio recorded. Although the agenda differed for the community participants and nursing home residents the broad topics of interest remained the same and included the following:

- Attitudes to Ireland as a multi-cultural society
- Preferences for care (e.g. who should provide care - where should it be provided)
- Plans for care in the future
- Experiences of and attitudes towards migrant carers
- Positive and negative aspects

In addition to these key topics, scenarios were constructed for the community dwelling group as examples of migrant carers caring for older people. These scenarios formed a basis for a discussion on issues that could arise surrounding care provision in such circumstances.

Seminar and Policy Forum

A one day seminar and policy forum was organised at the draft stages of the report to present the preliminary findings of the research project and to draw out cross-cutting themes from the Irish and UK settings. The aim of the forum was to provide the opportunity for stakeholders to discuss and contribute to the recommendations of the report and to create an awareness of the comparative elements of the research study. Participants included representatives of national statutory and voluntary stakeholder groups and government policy makers from across the ageing and migration sectors.

Older Adult Health and Social Care Sector



“For all the rhetoric about cherishing older people and the desire for equality and dignity in care relationships, the evidence suggests that there is considerably more to do before the stated objectives and aspirations of various policy documents are met.”

Introduction

This chapter details the current provision of health and social care for older people in Ireland at both community and residential care levels. The intention is to provide rationale and context for the discussion on migration and care provision that follows in subsequent chapters. The chapter begins with a discussion of population ageing in Ireland, followed by a short summary of our current knowledge on the health and well-being of older people in the country. A broad overview of community-based care for older people is then provided, including a discussion of family care and community care services. Residential care services for older people are also examined. Preferences for care and new models of care are explored towards the end of the chapter.

The majority of older people in Ireland are active, fit and healthy and live independently in their own homes. However, just under 5% of the older adult population live in long-stay residential care, while a further 15-20% receive varying levels of care in the community (Mercer, 2002). The rising interest in the provision of health and social care services for older people is associated with increasing concern over the fiscal implications of an ageing demographic. While Ireland currently has a relatively young population in comparison to its European counterparts, demographic trends suggest that Ireland will experience an ageing population over the coming decades (Pringle and Connell, 2004; CSO, 2006^a). Given our current favourable demographic structure, Ireland is in an optimal position to plan for future long-term care needs.

Changing demographics and the prevalence of disability along with economic and social trends, such as female participation in the labour force and family formation, will drive demand for formal health and social care services. Current provision for dependent older people depends significantly on families, who provide the bulk of care (Timonen and Doyle, 2008). This is partly because community care services remains fragmented and uneven, thereby placing the onus on families to provide most of the needed care. Establishing the optimal balance of care among families, communities and the State will become increasingly important as the population ages. Similarly, ensuring that older people have access to good quality residential care at reasonable cost will become even more important in the future, particularly if current public finance constraints widen and deepen. While this report is principally about care structures and patterns as they relate to migrant carers in the health and social care sector, the nature of the care system, in its entirety, matters for the lives of migrant workers and the older people under their care.

Population Ageing

In comparison to Europe, Ireland has a relatively young population. According to the most recent Census in 2006, there are 467,926 people aged 65 and over living in Ireland, which equates to 11% of the Irish population. This is in comparison to 16.8% aged 65 and over in the EU-27 (CSO, 2006^a). Despite changes in the absolute population levels, there has been little fluctuation in the proportion of older people in the Irish population over the last few decades.

There are a number of explanations for Ireland's relatively young population. First a high level of emigration during the 1950s has reduced the number of people currently in older age categories. Second, up until the 1980s, Ireland had a high birth rate resulting in a younger population in comparison to Europe. Third, during the first half of the 20th Century, Ireland experienced a slower improvement in life expectancy compared to the rest of Europe.

■ ² This chapter has been written by *Aoife Callan* of the *Irish Centre for Social Gerontology, National University of Ireland Galway*

However, demographic trends such as improvements in life expectancy, lower birth rates and migration suggest that Ireland will experience an ageing population over the coming decades. The Central Statistics Office (CSO) projects that by 2026, approximately 16% of the Irish population will be aged 65 and over, relative to 22% in Europe, with most of the growth occurring in the 65-74 age groups. By 2036, under all combinations for fertility, mortality and immigration, the number of older people in Ireland is likely to go beyond 1 million (CSO, 2006^b).

Much of the concern regarding population ageing stems from the potential impact on public finances. An ageing population will experience a decline in the relative size of the working population, thereby reducing the tax base for public financing (Barrett et al., 2006). In Ireland, the ratio of people of working age to people over the retirement age will decrease from 5.6 in 2006 to 1.8 in 2061 (Department of Social and Family Affairs, 2007). Similarly, as the government spends relatively more on pensions and health care for older people, less will be available for spending elsewhere, raising the possibility of inter-generational conflict regarding the allocation of scarce public resources. For example, it is estimated that age-related spending in Europe will rise from 5% of GDP currently to 13% by 2050 (SHARE, 2008). While shifting demographics may be one contributing factor to increasing demand for health and social care services, the need for health and social care services is also important. This is presented in the next section.

Health and Disability

Health is an obvious indicator of need in later life, as are levels of and trends in disability. Nowadays, better living and working conditions have enabled the EU citizens to live longer without needing any extra health or social care (Litske, 2006). Cutler et al. (2001) predict a reduction in the prevalence of disability in future generations due to medical and technological innovations, along with improvements in life expectancy. On the other hand, current bad behaviours among younger generations in relation to diet and exercise may yet see a rise in disability in line with increases in obesity-related diseases. There is no data in Ireland to allow us to say anything about likely trends in disability, but there are indications of improvements in life expectancy at older ages in Ireland, after decades of stagnation. At age 65, men in Ireland can now expect to live another 17 years. Women at that age can expect to live another 20 years (CSO, 2009).

According to the most recent Census in 2006, almost 394,000 persons, representing 9.3% of the total population, reported a long lasting health problem or disability³. The proportion is much higher for those aged 65 and over with 130,000 older people, equivalent to 30% of all older people, indicating that they had a disability. The Census indicates that the proportion of people with a disability increased with age. Of persons aged 70-74, 31% reported a disability rising to 42% for those aged 80-84. Of the 85 and over age group, 59% reported a disability. There was also a higher incidence of disability among females than males; 32% of females in comparison to 27% of males. This can be directly linked to lower mortality among females, especially among those aged 75 and over (CSO, 2006^a).

The EU SILC data 2005 (CSO, 2005) estimated the extent to which people's health status limits them in their everyday life. Almost half of older people report some restriction in mobility in comparison to 16% of those aged 15 to 64. A sharp increase of limitation in activities is associated with age as 57% of people aged 75 and over report some limitation compared with 39% of those aged 65 to 74. According to the Social Inclusion Report on Older People in 2007, only one in six older people in Ireland considered their health to be 'very

■ ³ Data on disability was derived from answers to questions on long-lasting conditions (question 14, 15 and 16) of the 2006 Census of Population questionnaire.

good' compared with one in two of the working age population.⁴ As would be expected, there were differences in perceived health status by age within the older age group.

The Mercer Report (2002) estimated the prevalence of disability in Ireland using disability prevalence rates from a UK survey carried out in the mid-1980s, modified for use on the Irish population. Based on this methodology, the Mercer report estimated that 70,000 older people living in the community in Ireland were in need of care because of disability, with 31,000 of these, requiring high or continuous care.

In terms of cognitive and mental health, approximately 38,000 people in Ireland have dementia, with over 60% of these affected by Alzheimer's disease (O'Shea, 2007⁵). By 2026, there will be approximately 70,000 people with dementia in Ireland with numbers expected to increase to over 100,000 by 2036. Estimates of the number of people with dementia in residential care varies, but international evidence suggests that between 30% and 65% of residents are affected (Knapp et al., 2007; McDonald et al., 2007). In Ireland the majority of people with dementia live at home; most of these people are cared for by family with low levels of support from statutory sources. We discuss the issue of community-based care for older people in the following section.

Community-Based Care

In Ireland, as with many countries in Europe, informal care has been the cornerstone of long term care provision for older people. Changing demographics and increasing female participation in the labour force, however, indicate that reliance on informal care may no longer be a sustainable model of long-term care (Timonen and McMenamin, 2002). While there is no evidence to suggest that families will stop care giving in the future, increasing numbers of older people and a reduction in numbers of potential carers will necessitate a greater involvement of the State in the care of older people. As is highlighted in the most recent health strategy; Quality and Fairness: A Health System for You (Department of Health and Children, 2001), *"The Health Strategy must take account of the changing role of the family and community and improve supports for community and family participation in voluntary and informal care."* Like many other countries in Europe, the Irish health and social care system are trying to reorganise the division of care responsibilities, in order to establish a sustainable balance among providers of care such as; the family, the market, and the State (Bettio and Plantenga, 2004). Long-term care provision in Ireland is characterized currently by a 'welfare mix' involving family, public, voluntary (community) and private provision and financing (OECD, 2005). There is no doubt however, that families are the cornerstone of existing provision.

Family Care

Based on the 2006 Census, there are 160,917 informal carers in Ireland, the majority of whom are women. This figure includes all those persons aged 15 years and over providing regular unpaid personal help for a friend or family member with a long-term illness, health problem or disability (including problems due to old age). This means that the data presented is not specific to care provided to older people. Estimates from elsewhere (O'Shea, 1999; Mercer, 2002) suggests that approximately 100,000 family carers, or two thirds of all carers in the country, are engaged in the provision of care to older people.

As is shown in Table 3.1, 58% of unpaid carers provide between 1 to 14 hours of care per week with 25% providing 43 or more hours of care a week (CSO, 2006).⁵ While the majority of unpaid care is provided by people aged between 45 to 64 years of age, 11% of unpaid carers are aged 65 and over.

■ ⁴ There were five health status categories: Very good; Good; Fair; Bad; Very Bad.

⁵ Receipt of Carer's Allowance was not considered payment for care provided.

Such a reliance on informal care provision suggests that shifting demographics and increasing female participation in the labour force warrant cause for concern for future public expenditure on long-term care provision for older people in Ireland.

Table 3.1 Breakdown of unpaid carers by hours of care provision, gender and age group

	Male carers (as % of total male carers)	Female carers (as % of total female carers)	Total carers	Aged 65 and over	Aged 15 -44	Aged 45-64
1-14 hours a week	60.0	56.8	58.0	37.0	63.8	57.7
15-28 hours a week	10.3	10.8	10.6	8.2	10.6	11.3
29-42 hours a week	6.7	5.5	6.0	6.2	6.4	5.5
43 or more hours a week	23.1	26.8	25.4	48.6	19.2	25.6
Total number of carers	60,703	100,214	160,917	18,152	69,885	72,880
Percentage of carers	37.7	62.3	100.0	11.3	43.4	45.3

Source: Census data, Central Statistics Office (2006)

“...Ageing has led to an increased demand for care services, compounded by the growth of independent living among the older population. Increased labour force participation by women reduces the number of those who traditionally have been the main providers of care” (OECD Report, A Caring World 1998 in EU Equal Community Initiative Programme Report, 2008)

One way to evaluate future demand for health and social care services is to calculate projected family caretaker potential. Since the majority of unpaid care is provided by women aged between 45 and 69, we can estimate caretaker potential by dividing the number of women aged 45 to 69 by the number of older people in the population who may require some level of care, namely those aged 70 and over (O’Shea, 1993). Table 3.2 presents caretaker potential for 2006 and projected caretaker potential up to 2036.

Table 3.2 Caretaker potential, 2006 to 2036

	Women aged 45-69/ Population aged 70+	Women aged 45-69/ Population aged 75+
2001	1.6	2.5
2006	1.7	2.6
2011	1.7	2.7
2016	1.6	2.7
2021	1.5	2.4
2026	1.4	2.2
2031	1.3	1.9
2036	1.1	1.7

Source: Data from CSO Population and Labour Force Projections (2004), based on M1F1 assumptions.

In 2006, the caretaker ratio of women aged 45 to 69 to those aged over 70 was 1.7. As is evidence of our young population, we see an increase in this figure to 1.7 up to 2011. However, after 2011, the ratio begins to decline steadily to 1.1 in 2036 reflecting changing demographics and our projected ageing population. There is a steeper decline in caretaker potential when over age 75 population estimates are used. The ratio of women aged 45 to 69 to those aged 75 and over is 2.6 in 2006 but decreases to 1.7 by 2036. The decline in caretaker potential suggests a reduction in availability of informal care and therefore, highlights a need for the greater involvement of the State in the care of older people in the future.

The caretaker potential does not take into account female participation in the labour force. A higher proportion of women entering the labour market, along with social factors such as changes in family composition, also suggest a future reduction in informal care. In Ireland, female participation in the labour force grew from 47% in 2002 to 53% in 2006. The female participation rate is growing at a faster rate than male participation rates in the labour force with the gap between male and female participation rates at its lowest ever in 2006 (CSO, 2006^a). Not only are more women participating in the workforce, but the percentage of women aged 15 years and over describing their status as 'looking after home/family' declined from 55% in 1982 to 22% in 2006.

A significant number of people providing informal care may also continue to work in the paid labour market. Therefore, while the population projections and increasing participation of women in the labour force implies a smaller pool of future informal carers, there may not be a proportionate decline in care potential. What may be of more concern is evidence of the current levels of stress and strain on informal carers (O'Shea, 2003^a). Informal carers are currently being asked to do too much with little or no support from the statutory sector and the enormous strain on informal carers directly impacts the willingness of families to care for older people now and in the future (O'Sullivan, 2008).

There have been moves towards providing financial support measures for family carers through social welfare policies. The Carer's Benefit, introduced in 2000, is a social insurance payment for those who leave employment to care for a person needing full-time care. The Carer's Allowance is a means tested payment targeted mainly at carers on low income who care on a full time basis (Comhairle, 2008). The Carer's Allowance for both under 66 years of age and over 66, increased by €14 in the Budget 2008 bringing the weekly average to €214 for under 66 years of age and €232 for 66 years and over (Department of Social and Family Affairs, 2008). In 2005, there were only 867 carers in receipt of the Carer's Benefit, up from 50 people in 2000. There were 24,970 carers in receipt of the Carer's Allowance in 2005 in comparison to 16,478 in 2000, (CSO, 2006^a). In 2007, the Carer's Allowance scheme changed to allow those providing full-time care and attention to another person to keep their main social welfare payment and receive half-rate Carer's Allowance. This will provide recognition of care provision to a greater number of informal carers. However, the numbers of carers receiving financial support is low relative to the total number of people providing care.

Community Care

Recent innovations in community care in Ireland have focused on the introduction of designated home care packages for older people living at home. The latter are additional support measures over and above existing community based services and are designed to maintain an older person at home through home supports and rehabilitation services (Health Service Executive, 2008). They are targeted towards people on the margin of long-stay care. Introduced in 2006, the most recent official data suggests that approximately 8,000 people benefited from a home care package at any one time in 2007, at a cost of €110m per annum (PQ 15143-08). However, notwithstanding such innovation, community care service provision is based on a budget constrained, supply-

side driven model, partly due to the absence of a legal basis for many services, with provision determined more by the needs of the provider than the needs of the older person.

Community care services for older people in Ireland are currently concentrated on public health nursing and home help provision (O'Shea, 2007^b). Public health nurses provide front line support for dependent older people living at home, though it is acknowledged that provision relative to need is not satisfactory given the demands on the service (NESF, 2005). Home help can also be critical in allowing older people to remain in their own homes for as long as possible and practicable. In 2007 approximately 53,000 older people were receiving an estimated 11,780,000 home help hours across the country (Health Service Executive, 2008). However, under section 61 of the *Health Act 1970*, the HSE are empowered, but not obliged, to provide home helps resulting in the service being discretionary and subject to the vagaries of budget allocations (NESF, 2005). Moreover, home help provision is often viewed as a substitute for informal care rather than a complement to family provision (Bolin et al., 2008). This has implications for the assessment of need for home help.

Day Care and Respite Care

Day care and respite care are an integral part of delivering a comprehensive community service for older people and their carers (Equality Authority, 2008). There were approximately 21,300 day care places provided across the Republic of Ireland in 2007, while respite beds account for 4.4% of total long-stay beds (Department of Health and Children, 2008^a). A respite care grant is available to help provide financial relief for those in need of respite services. Day care provision is more often than not provided by local community and voluntary groups and, where available, is an important support, even for one day a week. However, there are not enough places available given existing levels of need. Similarly, respite care provision is low and unevenly distributed across the country.

Housing and Transport

Housing and transport are also essential in allowing older people live independently in the community and unmet need in either can result in people being admitted to residential care unnecessarily. Various initiatives including The Rural Transport Initiative, which was launched in 2001, have demonstrated the importance of transport in supporting older people to continue living in the community. Free transport for older people has been an important concession, even if sometimes public transport is not available for older people to exercise their travel pass, particularly in rural areas. The Rural Transport Initiative involves 34 schemes in 25 counties. In 2004, an estimated 500,000 passengers used the scheme with 66% aged 66 years and over (O'Shea, 2007^b). The success of the scheme suggests the potential of the initiative nationwide.

In excess of 80% of older people own their own house, with housing conditions improving greatly over the last few decades. An NCAOP report, by Cullen et al. (2007), on supportive housing stated that *"the standard and suitability of older people's accommodation is vital to their health and quality of life and a key factor in their capacity to take care of themselves or to be cared for should they become dependent"*. Recent partnership agreements; Towards 2016: Ten-Year Framework Social Partnership Agreement 2006-2015 (Department of Family and Social Affairs, 2006), and the National Action Plan for Social Inclusion 2007-2016 (Department of Family and Social Affairs, 2007), have acknowledged that good quality housing is critical for independent living and achieving the 2001 Health Strategy goals of improving quality of life for older people.

Older people's housing needs usually arise from repairs and adaptations to current accommodation or the need to move to more suitable housing (Stratton, 2004). In recent years, there have been a number of schemes

available from various sources. The Essential Repairs Grant was administered by the Local Authorities, whereas the Special Housing Aid for the Elderly was administered by the HSE. In November 2007, the Housing Aid for Older People Scheme replaced both of these and is administered from the housing section of the Local Authority (Comhairle, 2008). It is estimated that approximately 10% of older people may be in need of housing repairs and/or adaptations in order to continue living in the community (Delaney et al, 2008). For some older people, housing repairs and adaptations may not be sufficient to maintain them in their own homes and may require, or prefer to, move to more suitable housing.

Supportive housing, which incorporates group schemes of older people's dwellings and sheltered housing and is a subset of social housing, targets older people on low incomes with housing difficulties and/or social or other welfare needs (Cullen et al., 2007). Approximately 2% of older people in Ireland live in supportive housing. Most of this housing is provided under the Capital Assistance Scheme and such accommodation has positive aspects for improving independent living in the community. The limited Irish data available suggests that supportive housing may be cost-effective in comparison to residential care in the care of dependent older people (Cullen et al, 2007).

Long-stay Residential Care

Residential care is currently provided through a combination of private and public facilities and will always be required for highly dependent older people who cannot remain living at home (Table 3.3).

	HSE Extended Care Unit	HSE Welfare Home	Voluntary Home/ Hospital for Older People	Voluntary Welfare Home	Private Nursing Home	Total
Total long-stay beds	5,206	1,406	1,496	320	13,285	21,713
Total limited-stay beds	1,207	164	359	37	7	2,485
Total undesignated	0	24	0	0	31	55
Total beds	6,413	1,594	1,855	357	14,034	24,253
Total residents	5,900	1,414	1,713	319	12,109	21,455
Per cent occupancy	92%	88.7%	92.3%	89.4%	86.3%	88.5%

Source: Summarised from Table B1, Long-Stay Activity Report (2006) – Department of Health and Children (2008)

There are a total of 24,253 non-acute beds in long-stay facilities representing 52 beds per 1000 older people. Private nursing homes provide the greatest number of long-stay beds in the system, although many of these beds are occupied by older people who would qualify for public care, if beds were available in public facilities. These people receive some financial support from the state to offset private nursing home charges. The high proportion of private beds is reflective of the introduction of various tax breaks which encouraged the establishment of private nursing homes and the reduction in the number of public long-stay beds in recent decades (O'Shea, 2003^b). Two thirds of all residents in long-stay care are female (Department of Health and Children, 2008^a). This is not surprising given the longer life expectancy of females and the age profile of residents in residential care.

Most residents in long-stay care (39.6%) are in the maximum dependency category, which means they require a high degree of nursing care and assistance because of significant disability (Table 3.4). However, 9% of residents



are in the low dependency group raising questions as to why they should be in residential care at all. Welfare homes, for example, have a higher proportion of lower dependency people as these were originally designed to meet the needs of dependent older people where relatives or other suitable persons were not available to provide them with care in their own homes (O'Shea, 1993). Quite clearly, there are significant numbers of lower dependency adults residing in residential care when it might have been possible to keep them at home were resources available to meet their largely social needs.

Table 3.4 Percentage of patients by dependency category for each long-stay facility

	Low dependency	Medium dependency	High dependency	Maximum dependency
HSE Extended Care Unit	6.1	17.3	32.8	43.9
HSE Welfare Home	13.7	18.5	28.8	39.0
Voluntary Home/Hospital	9.8	20.7	28.0	41.4
Voluntary Welfare Home	39.8	26.6	24.5	9.1
Private Nursing Home	9.2	21.4	31.2	38.2
All beds	9.1	20.1	31.1	39.6

Source: Summarised from Table B6, Long Stay Activities Report (2006) – Department of Health and Children (2008)

Unfortunately, it is not possible to compare the dependency information from the long-stay statistics with those from the community as the scales used to measure dependency differ across the data sources.

The Irish Care Workforce and Care Environments

CSO data show that there were 51,145 nurses and midwives working in Ireland in 2006, 9,405 nurse's aides and 31,711 care assistants and attendants. This means that the total number of people working in these areas combined was 94,261 in 2006. There is no detailed information on the breakdown of the care workforce by sector or setting. Therefore it is not possible to state precisely how many registered nurses and care assistants work in the older adult health and social care sector across public, voluntary and private institutional and community settings. Generally though, the older adult care workforce is considered to have a larger proportion of part-time workers and older workers near retirement than the other sectors of health and social care. Moreover, just as with the health and social care sector as a whole, the workforce delivering older adult care is predominantly female. Approximately 16% of this workforce is thought to be foreign national, which is slightly higher than the national/foreign national split in the general labour market (15%) and marks an increase of more than 5% since 2002 when 10.8% of the care workforce were migrants .

All registered nurses working in Ireland must be registered with An Bord Altranais (the Irish Nursing Board). In recent years, there have been efforts to enhance nursing as a general profession. This has resulted in changes in the education and training of nurses from a higher diploma to an honours degree, with the purpose of increasing the appeal of nursing as a profession. There has also been increased capital investment in nursing education facilities and additional monies for undergraduate nurse training (Quinn, 2006). Other incentives introduced to increase the supply of mature workers and students into the nursing profession include 'back to practice' courses for those out of the workforce and financial supports for nurses pursuing part-time degrees (Irish Nursing Board, 2006). In addition, the promotional structure within nursing has been improved and flexible working conditions have been introduced where appropriate.

While minimum training standards for care assistants have not yet been introduced, a FETAC level five award has been proposed for all care assistants. The FETAC award in 'Healthcare Support' is a general award type. In 2006 there were three new categories included for award certification including: 'care for the older person', 'care practice in community care' and 'care support' (FETAC, 2006). Due to the large proportion of care assistants in the older adult care sector, establishing a recognised qualification will serve to raise the profile of the sector with regard to its professional and public image. The HSE has implemented this requirement for all new care assistants, with many existing care assistants also updating their training. Many private long-stay care employers are following the HSE in using a FETAC level 5 qualification and sector wide implementation is hoped to be achieved in the coming years. Currently, the private home care sector has not adopted the FETAC qualification at a sector wide level.

The HSE were responsible historically for the inspection and registration of private and voluntary residential services for older people; public long-stay facilities were not subject to inspection or registration. However, due to some high profile cases of institutional neglect and abuse of older residents in 2005, and subsequent demands for an independent inspectorate, new standards, regulations and inspection units have recently been introduced for all long-stay facilities. In March 2009 the 'National Quality Standards for Residential Care Settings for Older People in Ireland' were published by the Health Information and Quality Authority (HIQA) - an independent authority reporting to the Minister for Health and Children. These standards deal with such areas as residents' rights, protection, health and social care needs, quality of life and staffing, and, following recent legislative enactment, will serve as a basis for the new system of registration and inspection administered by HIQA's Social Services Inspectorate.

In the case of care delivered in a person's own home, older adult home care provision, whether provided through statutory, voluntary or private means, remains unregulated in Ireland. Currently, the Irish Private Home Care Association is campaigning for the introduction of such standards.

Preferences and Preparation for Care

After describing the community and long-stay structures for the care of older people in Ireland, it is important to briefly consider what kind of care people want as they grow older. This section outlines the general care preferences of older people as articulated in recent studies and reports. The preferences for care of older people participating in this research, and the role of such preferences in shaping the demand for migrant carers, will be outlined in Chapter 6.

It has long been established that the majority of people wish to be cared for in their own home for as long as possible with sufficient health and social care supports to do so. Garavan et al. (2001) in the HeSSOP report found that living at home with the provision of respite care services was preferred by 87% of respondents. In an ESRI survey, 4 out of 5 adults interviewed felt it was 'very important' to stay at home for as long as possible if long-term care was required, with a strong preference for care delivered by family and friends (Williams et al., 2006). Irish preferences are in line with people in other European countries. The Special Eurobarometer Report (2007) found 81% of Europeans would prefer to be cared for in their own homes through a variety of sources compared to just 8% who prefer to be cared for in a long-term care institution.

While people may prefer to be cared for in their homes by family and friends, there appears to be little preparation by Irish people for long-term care need in the future. Table 3.5 presents the level of preparation made by Irish people for potential physical and mental health deterioration.

**Table 3.5 Long-term care preparations**

	Save money for care or take out insurance for care	Speak to family about possible future needs
Done so already	23	9
Intend to	17	15
Should do it	24	18
No intention	25	34
Don't Know	11	19

Source: Adapted from *Special Eurobarometer Report, 2007*

Although the data presented in Table 3.5 is inclusive of all age groups from 15 years upwards, the high proportion of those with no intention of either financially preparing for older age, or discussing care options with family is a cause for concern. Lack of long-term planning may be due to the historical reliance on the public health care system in Ireland for long-term care provision and a view that the State will always be able and willing to support care needs as people grow older and potentially become dependent.

Recalibrating Existing Care Structures

Health and social care policy for older people in Ireland has evolved over the last 40 years. The Care of the Aged Report in 1968, first encouraged a shift away from institutional care to community based care for the care of older people in Ireland, recognising the preferences of older people to remain in their own homes for as long as possible. Since the 1968 report, the call for further development of community based care is echoed in a number of health and social care policy reports. The 1988 Years Ahead report: A Policy for the Elderly highlighted the need for the development and practice of home based care for older people and recommended greater state involvement with coordination between the State, public, private and voluntary care providers and informal carers. The report called for the development of a model that maintained older people in their homes where possible and practical, and provided high quality long-stay care, including rehabilitation, where required. The importance of the Years Ahead report was recognised in 1993, when it was adopted as official government policy. It remains official policy at the time of writing in 2009.

In 1997, the National Council on Ageing and Older People (NCAOP) evaluated the Years Ahead achievements against stated objectives and found a number of shortcomings. In particular, community services were deemed to be fragmented with little coordination among services, between health boards and local authorities, public and private sectors and between community and residential care (O'Shea, 2007^b). That criticism remains valid in 2009 and was articulated in the 2005 NESF: Care for Older People report which suggested that much more needs to be done to make community care provision a reality in Ireland. The problem is partly one of underfunding for community care and partly one of failure to make the best use of existing resources to support people living in their own homes.

Ireland spent approximately 0.62% of GDP on long-term care for older people in 2005. It is estimated that Ireland will need to spend an additional €500 million to bring long-term care expenditure up to the OECD average (NESF, 2005). The key question is how any additional expenditure is to be funded, given that demands on the system are likely to increase in the future.

Over the last few decades, residential care has absorbed the majority of long-term funding in the country, through public provision and support for private provision through the Nursing Home Subvention Scheme. Assessment for public long-stay care was based on income, housing situation, family and health (O'Shea, 2003^b). Practically everyone was liable to pay nominal income-related charges for public nursing home care; the maximum charge is currently fixed at €120 per week, equivalent to about 10% of average weekly costs of care. However, there has not been enough public beds to satisfy existing need, requiring a significant number of people eligible for public beds to enter private nursing homes, where cost-sharing is considerably higher, even with public subventions. In 2007, 7,800 older people were in receipt of the Nursing Home Subvention supporting care in private nursing homes, with more than half of these in receipt of enhanced subvention (Health Service Executive, 2008). Current costs of care in private nursing homes vary depending on provision and location but weekly costs are close to an average of €1,000. While some of this gap can be met through enhanced subvention, older people and their families are left with considerable out-of-pocket payments, up to two thirds in some cases, considerably more than if they were being looked after in a public long-stay facility.

The government has recently proposed a new funding model for long-stay care in Ireland, the Fair Deal scheme, currently going through the Oireachtas (parliament). The aim of the new scheme is to make long-stay care financing more efficient, equitable, transparent and biased towards care in the community. In the new scheme, there will be more formal assessment of care needs, with only high dependency older people receiving financial support for residential care. In regard to cost-sharing arrangements for residential care, the older person will continue to pay an out-of-pocket contribution, which is less than their current pension, with a possible deferred joint contribution of 5% of housing assets per each year of care. The latter is capped at three years of care and 15% of the value of housing assets for a couple (Department of Health and Children, 2008^b). Not surprisingly, the proposal and subsequent legislation has been controversial given the changes to cost-sharing relationships and the inclusion of a retrospective deductible payment in the form of housing assets. That said, the system has the capacity to bring greater efficiency and equity into the system. The key question is whether the new scheme will deliver more resources for community care. Some commentators have argued that a social insurance system would be more likely to generate the reforms necessary for a more community-based system of care (O'Shea, 2007^b).

Conclusion

The vast majority of older people in Ireland are in good health and do not place any additional demands on the health and social care system. However, for those that are dependent and in need of care, current community care provision is weak and fragmented which places huge care pressures on older people and their families. While family care has been the backbone of long-term care provision in Ireland, changing demographics and increasing female participation in the labour force suggest that this model may no longer be sustainable. The stress and strain of providing informal care along with decreasing numbers of available carers suggests the need for further public investment in community care. Residential care is also under the spotlight with a new funding model about to be implemented, alongside greater accountability with respect to quality of care provision and quality of life outcomes for residents.

It is impossible to examine the role of migrant workers in the Irish health and social care system without reference to the policy and practice environment within which they work. Migrant workers provide care in a system that is under-funded and historically under-valued by the society that it serves. For all the rhetoric about cherishing older people and the desire for equality and dignity in care relationships, the evidence suggests that there is considerably more to do before the stated objectives and aspirations of various policy documents are met.

Responding to the Challenges of Migration in Ireland



“Ireland is no longer a country where immigration can be regarded as a short-term or transient issue.”

Introduction

Like the previous chapter, it is important to set out the broader migration environment into which migrant workers in the health and social care sector have entered in recent years. Migration has been a feature of Irish society and the Irish economy for many centuries, specifically in the form of outward migration of our own people to other countries, especially to the US, UK, Australia and Canada to a lesser extent. It is only in recent years that we have experienced inward migration of significant numbers of people to Ireland with no previous connection to this country through race, blood or even economic ties. The level of inward migration was largely unforeseen, resulting in considerable dislocation and disequilibrium for both migrants and the host society. This chapter sets out some of the main issues in respect of recent migration practice and policy in Ireland and provides an important background for the interpretation of data on migrant carers in the health and social care sector in subsequent chapters.

Global Perspectives

'Migration is one of the defining issues of the 21st century' (McKinley, 2008).

We live in an age of migration. The world is growing ever smaller and inter-dependent because of the effects of globalisation. At the same time, a combination of neo-liberal economic restructuring, uneven demographic development, low-cost travel and ease of communication have brought about an upsurge in international migration. According to the International Organisation for Migration,

"There are now about 192 million people living outside their place of birth, which is about three per cent of the world's population. This means that roughly one of every thirty-five persons in the world is a migrant. Between 1965 and 1990, the number of international migrants increased by 45 million - an annual growth rate of about 2.1 per cent. The current annual growth rate is about 2.9 per cent." (IOM, 2008^a)

As the UN Population Division points out, the international migrant population in the 1960s was only 75 million, although it should be noted that, as the world population was much smaller at that time, this still amounted to about 2.5% of the total world population (UN, 2006^a).

The above statistics also suggest that migration should be kept in perspective. Given a choice, most people prefer not to leave their home countries. However, there are important regional variations. About one in ten persons in the world's more developed countries is a migrant, compared to just one in seventy in developing countries. The region with the largest number of migrants is Europe (64 million), followed by Asia (53 million) and North America (45 million). In developed countries female migrants outnumber males. These figures do not include undocumented migrants, who probably number a further 30 to 40 million worldwide (UN, 2006^a).

Future trends suggest that further increases in international migration, possibly on a dramatic scale, are likely. A recent IOM report on climate change and migration points out that 'on current predictions the "carrying capacity" of large parts of the world will be compromised by climate change' (IOM, 2007, p 13). The section of the report regarding the attitudes of national governments towards the phenomenon bears repeating:

■ ⁶ This chapter has been written by Piaras Mac Éinrí of the Migration Studies Unit, Department of Geography, University College Cork

“However, there has been a collective, and rather successful, attempt to ignore the scale of the problem. Forced climate migrants fall through the cracks of international refugee and immigration policy—and there is considerable resistance to the idea of expanding the definition of political refugees to incorporate climate “refugees”. Meanwhile, large-scale migration is not taken into account in national adaptation strategies which tend to see migration as a “failure of adaptation”. So far there is no “home” for climate migrants in the international community, both literally and figuratively.” (IOM, 2007, p 14).

A widely quoted estimate for the number of environmental refugees by 2050 is 200 million, (IOM, 2007) which would represent approximately a ten-fold increase on the present figure for international refugees. It will also be noted that it would exceed the figure quoted above for the total current number of international migrants. However, while it appears a virtual certainty that climate change will have *some* effect on migration, there is really no way of estimating with any degree of accuracy the complex interactions between issues of climatic and environmental change and the likely human responses; figures cited range from 150 million or fewer to 1 billion (IOM, 2008^b).

International Migration

Even if one discounts the more alarmist scenarios presented by the possibility of large-scale involuntary environment-driven migratory movements for the moment, there can be no doubt that the volume of international labour migration shows an upward trend which is likely to continue into the future. There has been a tendency to portray high-skills or professional migration as essentially *demand-driven*, given a worldwide shortage of certain occupations in high demand, whereas lower-skilled migration is seen as more of a *supply-side issue* as people attempt to escape from demographically, socially and economically challenging situations through international migration. Developed countries have sought to incentivise immigration by persons in the former category through special programmes offering additional rights and entitlements compared to ‘ordinary’ migrants, while attempting at the same time to control the movement of the latter through restrictive measures, quota-based regimes, temporary non-renewable permits, the use of agency or contract arrangements and the like. This is often done against a backdrop of a moral panic concerning the volume of immigration and the alleged threats it poses from a political, economic or socio-cultural perspective.

The reality is more complex than this over-simplified two-part typology might suggest. Huge wage differentials between different world regions and within the EU itself have attracted migrants from a wide range of backgrounds. The fundamental restructuring of the economies of western developed countries has led to the loss of manufacturing to other parts of the world. Indigenous workers in developed countries have been up-skilled for the new ‘knowledge economy’, although significant sections of the workforce have experienced socio-economic marginalisation as they have found themselves excluded, unable or ill-equipped to deal with the challenges of an increasingly post-industrial society. Increasing levels of wealth, albeit accompanied by increasing levels of inequality, have seen the expansion of new forms of service employment as well as the return of old ones in such fields as personal care and domestic services.

In that sense, therefore, it is an oversimplification to view migration as a simple matter of ‘desirable’ high-skills migrants fuelling economic growth onwards and upwards and less desirable ‘ordinary’ migrants doing the jobs no-one else wants to do. Changing socio-economic structures and cultural norms, including the disappearance of the kind of services once provided in countries like Ireland by faith-based organisations, mean that migrants with many differing kinds of skills are needed in many different sectors of the economy.

The growth in demand for older adult care, in the context of wealthy ageing societies with increasing levels of life expectancy, should be seen in this light.

Many migrants actually have high levels of education up to and including a range of professional qualifications, but are doing work which is not commensurate with their training and expertise. From the standpoint of the sending countries, concern has arisen over the number of high-skills professionals, trained in developing countries, who migrate to work in the developed world. As the Report of the Global Commission on International Migration points out, by 2000 only about 50 of 600 doctors trained since independence were still practicing in Zimbabwe; it was estimated that there were more doctors from Malawi practicing in the northern English city of Manchester than in the whole of Malawi itself (GCIM, 2005). A debate is now growing over the links between migration and development, spurred on by data which indicates that migrant remittances play a far more significant role than official development aid in improving the economic circumstances of people in developing countries. As the GCIM report notes,

“Remittances are now close to triple the value of the Official Development Assistance (ODA) provided to low-income countries and comprise the second-largest source of external funding for developing countries after Foreign Direct Investment (FDI). Significantly, remittances tend to be more predictable and stable than FDI or ODA. They continued to rise during the Asian financial crisis, for example, even as flows of FDI fell. This is not an isolated case. Evidence collected by the World Bank indicates that when a country encounters political or economic difficulties, citizens who are living and working abroad support their compatriots by increasing the amount of money they send home.” (GCIM, 2005, p. 26).

It could be argued that this is a slightly disingenuous viewpoint, as remittances represent an essentially privatised flow of funds whereas the development of improved public infrastructure is likely to largely depend on targeted development aid, whether government to government or through other structures such as the NGO sector.

Channels of Migration

To summarise the above, the international movement of persons currently gives rise to a number of quite different types of flow.

- Programmes aimed at high-skills migrants with specific qualifications. These may be employer-driven or state-operated, quota-based and/or using a range of selection criteria. Examples are the US ‘green card’ and the German or Irish equivalents, even though the latter are not strictly equivalent as they do not provide for permanent residence. Family reunification rights usually apply.
- Programmes providing for other categories of labour migrants. These may provide for fewer rights and entitlements, may be limited in time and may or may not provide for family reunification. The general principle followed in such cases is that rights and entitlements are extended progressively over time.
- Guestworker programmes including such categories as seasonal agricultural labourers, contract labour and agency labour. These are usually short term and often non-renewable in duration and do not provide access to rights and entitlements except on a limited or emergency basis. Family reunification is frequently not provided for. Critics say that such programmes are inherently exploitative and drive down wage levels and working conditions for both migrants and host community workers. There were nearly 34 million temporary admissions to the US in 2006, twice the number which took place in 1990 (Batalova, 2008).

- Family reunification programmes represent a specific and important category in themselves. Thus, while the post 1973 ‘immigration stop’ in most European countries led to a substantial decrease in labour immigration, family reunification increased dramatically as workers chose to stay put, in the knowledge that if they went home they would not be able to return, and accordingly sought to have their families join them. While some countries have restrictions on employment for people who enter through family reunification, a number of other nations rely on this channel for a significant proportion of their labour supply.
- Asylum seekers and refugees. The number of asylum seekers arriving in the developed world has fallen in recent years, mainly because countries have made increasing use of punitive administrative measures including detention and carrier sanctions to discourage would-be applicants. The number of programme refugees accepted by governments as part of UNHCR’s refugee resettlement programme continues to be modest: only 133,200 in total for the period 2002-2006 (UNHCR, 2006). However, once asylum seekers and refugees are accepted into a country, they typically have unrestricted access to the labour market and thus for many nationals, as with those entering under family reunification, form a substantial source of migrant labour.
- Undocumented migrants and their families. An oft-quoted estimate places the number of undocumented workers in the US at 11-12 million, the equivalent of more than 30% of the documented migrant population or about 3% of the total population (Hoeffler, Rytina and Campbell, 2006). Estimates for EU countries vary widely, while the first study into the topic in Ireland, announced in 2007, has not yet been published.

In the case of migrants working in the older adult care sector, some are likely to be drawn from the high-skills migrant category, in the case of qualified nursing personnel, but many are likely to be in the second category above, with fewer rights and a lack of permanence. Others may find themselves in an undocumented situation, either from the outset or because employers have failed to maintain them in a regular situation.

EU Perspectives

The first forty years of the European Communities/European Union saw relatively little progress in the direction of a joint approach to migration, still less the development of joint policies and shared sovereignty. This was hardly surprising; migration policy was seen as a core *national* policy area (Katrougalos, 1995). Most migration flows either reflected traditional bilateral links, defined in part by geography, culture and politics (e.g. Finland to Sweden; Ireland to Britain, Italy to France and other parts of northern Europe; Portugal to France) or were a by-product of colonial relationships with countries in other regions of the world.

Beginning in the 1980s, the EU gradually became more and more involved in migration issues. One reason was the introduction of the Schengen arrangements, including the abolition of border controls and shared information systems; Schengen was ultimately incorporated into the *acquis communautaire* through the Treaty of Amsterdam which entered into force in May 1999. That Treaty also provided for a transitional period up to 2004 during which it was intended that there would be a gradual transfer of sovereignty in migration matters so that it became an area of EU legal and policy competence. As will be seen shortly, it has not quite worked out that way yet. Meantime, the rise of asylum and refugee issues (in part, because the ‘immigration stop’ of the 1970s had made it increasingly difficult and often impossible for would-be migrants to find a legal way into a region with growing labour shortages) became a matter of political and public concern. The Dublin Convention 1990

(which provided that one could normally only apply for asylum in an EU country once, in the country of first arrival) was followed by the outbreak of military hostilities in Bosnia Herzegovina. The substantial resulting flow of refugees into the EU focused almost exclusively on Germany, where many of the refugees had family connections. It became increasingly evident that there would need to be some kind of burden sharing if another such event were to occur, something which actually happened with the crisis in Kosovo in 1997-98. Later, the post 9/11 world catapulted migration to the top of the agenda as states became concerned with the alleged security risks posed by the possible movement of undesirable migrants across borders. An agenda largely dictated by security concerns has meant that issues of control and monitoring have taken precedence in recent years over issues of human rights and entitlements. Nevertheless some progress has been made on all fronts.

The EU's role is now moving increasingly centre stage. The European Council conclusions of December 2006 set out an ambitious 'Comprehensive European Migration Policy' (Council of EU, 2007) building on decisions taken at the Tampere European Council in 1999 (Council of EU, 1999), the Hague Programme of 2004 (Council of EU, 2004) and the Global Approach to Migration adopted in 2005 (Council of EU, 2006). An international cooperative approach is stressed, as is the need to recognise the linkages between migration and development. Much of the rhetoric disguises the real thrust of the policy, designed to slow down migration through measures designed to favour development in source countries, better security cooperation, more effective return and readmission arrangements and more effective methods to combat trafficking.

The shift towards new approaches is illustrated in the conclusions of the Foreign Affairs Council meeting of June 2007:

"The Council reiterates that active consideration must be given to how legal migration opportunities can be incorporated into the Union's external policies in order to develop a balanced partnership with interested third countries. These would need to be adapted to the specific EU Member States' labour market needs as well as to the cooperation results achieved from the third countries concerned."
(General Affairs and External Relations Council 2007).

On 23 October 2007 the European Commission made good on this new approach by proposing a common EU 'blue card' scheme, similar to the USA green card programme although far more restrictive in several key respects. Holders of an EU Blue Card would be treated just like EU nationals as regards tax benefits, social assistance, payment of pensions, access to public housing and study grants. According to the proposal, the Blue Card would be valid for two years, after which it could be renewed. It would also be revocable if the holder became unemployed for more than three months. Family members would be permitted to join the card holders (EU Commission, 2007). Much work remains to be done in this field.

A range of other proposals has also been adopted in recent years, a number of which are relatively modest in scope, in such areas as long-term residence status, family reunification and entry conditions for students and researchers. The first steps have also been taken in creating joint border patrolling arrangements (Frontex), while a set of (largely aspirational) principles (the Common Basic Principles) were published by the Dutch Presidency in November 2004 (Justice and Home Affairs Council, 2004). It is intended to have a Common European Asylum System in place by 2010.

UK, Ireland Opt-Out

The above notwithstanding, the UK and Ireland opted out of the Treaty of Amsterdam as far as migration policy is concerned. Moreover, both countries have continued to treat all subsequent proposals in the domain on a case by case basis and did not adopt the directives on long-term residence status, family reunification, students and

researchers. It remains to be seen what definitive attitudes both states will take with regard to the 'blue card' discussions. Ireland has stated on more than one occasion that its attitude is one of pragmatism rather than principle and stems from the need to preserve the Common Travel arrangements with the British side. On the British side, it would appear that consideration is still being given to the concept of a Britain of electronically sealed borders. Such measures could lead to the exclusion even of travellers from Northern Ireland, legally part of the UK, because it would effectively be impossible to police the land border between the two jurisdictions in Ireland (Sharrock, 2007). This could signal an effective end to the CTA, while opening up the intriguing, if unlikely, possibility that Ireland could then go its own way and join Schengen even if the UK did not.

Recent Trends: Inflows, Outflows and Economic Decline

The Irish experience of immigration has been dramatic, as the country shifted from a traditionally emigrant culture and became a substantial zone of immigration from the late 1990s on. Overall, according to the 2006 Census, migrants accounted for just over 10% of the population (see also annex 1 of the Census for a number of tables). A look at workforce statistics also confirms the growing significance of immigration in recent years. In the final quarter of 2007, foreign nationals accounted for 355,000, or almost 16%, of the 2.24 million members of the labour force (CSO, 2007^a). While this figure is said to have contracted slightly to 15%, the size of the workforce is itself still worthy of note, bearing in mind that only about a million persons were in paid employment in Ireland in 1986 (Mac Éinrí, 2005).

Gross immigration into Ireland for 2006/2007, at 109,500, was the highest on record (CSO, 2007^b). About half of this immigration is accounted for by the twelve new Accession States. Curiously, although Romanian and Bulgarian nationals do not have automatic admission to the Irish labour market, 17,371 Romanians had been issued with Personal Public Service Numbers – national insurance – by end of April 2008, the vast majority since accession in 2007 (Department of Social and Family Affairs, 2008). About a quarter of all immigrants in 2007 were from the 'rest of world' (i.e. not EU or US). Significantly, there has also been an increase in the category 'emigration' since 2002, to a level of 42,200 in 2007. However, a closer look at the countries of destination – 7,000 to the New Accession States and 19,000 to the 'rest of world' would suggest that the bulk of these movements are not made up of emigrants at all, but return migrants going back to their countries of origin (CSO, 2007^b).

The economic downturn accelerated in the second half of 2008, with some severe sector-specific effects, notably in construction, where nearly one quarter of all male workers – the highest level in the EU – were employed in recent years. The major 'unknown' is whether migrant workers will return home in large numbers, or whether they will choose to sit out the down-turn and wait for an upswing in an economy. Preliminary evidence suggests that in sectors most affected by the economic decline a considerable number of migrants are choosing to return home.

Future trends are obviously difficult to estimate and cannot be based on a simple linear extrapolation of existing data, as the recent collapse of the Irish economy bears out. Recent CSO projections indicated that if long-term growth rates in the Irish economy return to the trend rate of about 4%, which now seems very unlikely, labour force growth of some 2% per annum, would be required. The domestic labour market will not produce anything like the required number of workers, suggesting that a long-term requirement of up to 40,000 immigrants per annum will be needed (Tansey, 2008; CSO, 2008^c). However, it is difficult now, writing in mid 2009, to see 4% growth rates being achieved any time soon again, so immigrant requirements will be significantly reduced. Although, it is likely that there will be sectoral differences in both demand and supply.

Percentage of Foreign Health Professionals - Comparative OECD Data

Data published in the OECD's 2007 *International Migration Outlook* (OECD, 2007^b: see annex 2) on practicing health professionals by occupation and place of birth, although admittedly drawing on data from 1998-2002, throws interesting light on Ireland's comparative position in respect of health personnel. The percentage of foreign-born nurses at that time was 14.3%, compared to Switzerland (28.6%), Australia (24.8%), New Zealand (23.2%), UK (15.2%) and US (11.9%). For doctors the figure for Ireland was 35.3%, exceeded only by New Zealand (46.9%), Australia (42.9%); other figures were 35.1% in Canada, 28.1% in Switzerland, 33.7% in the UK, 24.4% in the US. For 'other health professionals' (e.g. dentists, pharmacists, veterinarians) the figure for Ireland was 28.1%, compared to New Zealand (38.6%), Australia (33.9%), Canada (32%), Switzerland (26.7%), UK (29.2%), US (20.9%). This would strongly suggest that Ireland is effectively already operating in a globalised labour market for these professions. Unfortunately similar data for older adult care workers is not available.

Immigration Policy up to the Recent Past

Immigration policy in Ireland needs to be understood in terms of the early 20th-century history of an impoverished state, an inward-looking and isolationist culture and an economy which up to the very recent past could not provide sufficient employment for Irish people, not to mention immigrants. Of course, some would suggest that this situation maybe upon us again, but that is a debate for another time. With the obvious exceptional case of British people, immigrants to Ireland in the period before the 1960s were confined to very modest numbers, including a small Jewish community, mainly settled in Dublin and Cork, small Chinese and Italian communities and small number of other 'aliens', the rather unfortunate legal term used then and now.

Irish attitudes and policies subsequently changed, of course, starting with the economic reforms of the late 1950s, the opening up of the Irish society and economy, membership of the EEC (now EU), and the later, dramatic transformations of the period from 1986 to 2006. But it is worth bearing in mind, in the midst of all these changes, that the core legislation for non-EEA workers and residents in Ireland is still the *Aliens Act* 1935 and the *Aliens Order* 1946. The reforms which have been made since 1946 mainly related to *specific categories of foreigners* and not to foreigners (or 'aliens' or 'non-nationals', to quote the repugnant terms still widely used by officialdom) in general. Thus, British people have never been treated in Irish policy and law as fully 'foreign' (to have done so would have called the position of the Irish in Britain into question). Moreover, EEC membership led to free movement of workers from other member states, a situation which was reinforced by such legislation as the Treaties of Maastricht (1992) and Amsterdam (1997), and the UN Refugee Convention, already referred to, led to a modest number of refugees (e.g. from Chile and Vietnam: see Reception and Integration Agency 2008) being given rights of residence and employment. In the recent past a range of rights-based legislation and policy (e.g. the *Equal Employment Act* 1998, *Equal Status Act* 2000 and *Equality Act* 2004) greatly improved conditions for all in terms of employment rights, the right to equality of treatment in service provision, and enhanced protection and redress against racism and discrimination (however, it must be regretted that the *Prohibition of Incitement of Hatred Act* 1989 has proved entirely toothless and that a promise made in 2002 to reform this legislation has not to date been honoured). But the fact remains that the majority of non-EEA migrants in Ireland, other than those married to Irish or EU citizens, are present in Ireland on terms and conditions which are usually temporary, conditional and discretionary.

The *Aliens Act* 1935 and *Aliens Order* 1946 (somewhat modified following a court challenge in 2004) are draconian provisions, reflecting their origins in First World War British legislation, adopted at a time when all foreigners were regarded with suspicion. Extraordinary, far-ranging and discretionary powers concerning

immigration are conferred upon the Minister of the day, who may take his or her decisions without explanation and without appeal. In the intervening years much of Irish immigration policy has been conducted by ad hoc ministerial orders, statutory instructions and confidential rules and procedures, with the unfortunate result that parliamentary scrutiny has only taken place on rare occasions and civil society has had little opportunity to develop an informed view of Irish immigration policy.

That said, it is not intended to suggest that the original harsh measures provided for in the legislation have not been blunted over the years by some degree of emerging custom and practice and a gradual opening of decision-making more generally to a greater degree of transparency and external scrutiny.

Labour Migration - Recent Policy Changes and Current Channels

With respect to labour migration, as well as developments that relate to immigration in general, the main recent developments have been as follows:

- *The Employment Permits Act 2003*: introduced by the Department of Enterprise, Trade and Employment, provided a revised legislative basis for work permits, including penalties for employers for illegal employment of non-nationals (up to then an offence only for non-national employees). It also made preparations for the implementation of free movement of workers from the new EU Member States in 2004.
- *The 'habitual residence' requirement*: was introduced into social welfare legislation on 1 May 2004, to limit the access of non-Irish nationals (including EU nationals) to many social welfare payments. The concept of 'habitual residence' is derived entirely from UK policy and practice. While intended to prevent alleged 'welfare tourism' within the EU, it has also led to returning Irish from outside the Common Travel Area being denied welfare and other entitlements (O'Brien and Healy, 2008).
- *The Employment Permits Act 2006*: Work permits are now generally only available, except in exceptional circumstances, for persons earning a minimum salary of €30,000 per annum. A labour market needs test is applied. 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. Family reunification can be applied for after 1 year. Certain occupations are ineligible for work permits. These do not include care workers. However, the minimum salary requirement may be restrictive for care workers. Essentially, the strict limits on categories of work for which a work permit can be applied for may be seen as a policy based on the view that EU10 Accession State citizens could fill such categories whereas previously they would have required non-EU workers (including workers from those very states which joined in 2004).

A 'green card' regime grants employment permits on more favourable terms to persons who either earn more than €60,000 per annum or who earn between €30,000 and €60,000 in a category considered to be in short supply. Registered nurses are considered to be in the latter category. The holder of a green card is entitled to immediate family reunification and a 'pathway to long-term residence', although an unclear pathway. This form of permit lasts for two years after which it is intended it can be renewed indefinitely. The green card scheme replaced the Work Visa/Work Authorisation categorisations used up to 2007, which many foreign national nurses had entered the country under.

Certain conditions e.g. changes of employer, the giving of the permit to the employee rather than

the employer, have been liberalised. Family members entering under family reunification were entitled under the *Employment Permits Act 2006* to obtain employment.

- *Revised Arrangements for Employment Permits*: In response to the current economic downturn, revised arrangements for employment permits were introduced on the 1st of June 2009 affecting both new work permit and green card applications in the future.

Additional occupations were added to the ineligible list for work permits. While these do not include care workers, they do include domestic workers. At the time of writing, it is unclear whether this new restriction will affect carers working in people's homes. The minimum salary criterion of €30,000 for work permits has been reinforced and the labour market needs test has been extended to 8 weeks, with 6 days advertising in national media. The spouses and dependents of work permit holders must now apply for a work permit in their own right according to standard work permit eligibility criteria if they want to obtain employment.

Additional occupations have also been removed from the eligible list for green cards, but do not include registered nurses (midwives are included). The spouses and dependents of green card holders are still permitted to obtain employment.

- *Immigration, Residence and Protection Bill*: In 2004 a discussion document on Immigration and Residence in Ireland (Department of Justice, Equality and Law Reform, 2005^a) was published. Following further consultations, a Bill on Immigration, Residence and Protection, intended to supersede all previous legislation, is before the Oireachtas (Houses of Parliament). The Bill has had a turbulent history, however and several hundred amendments have been proposed by the Government's own side as well as by opposition parties. At the time of writing the Bill (referred to as the *Immigration, Residence and Protection Bill 2008*) is at the court stage of the process.

An important step forward in 2008 has been the establishment of the *National Employment Rights Authority*. Agreed under the Social Partnership Agreement 'Towards 2016', this body has information in 13 languages on employment rights and entitlements as well as powers of enforcement and prosecution. Its team of 90 labour market inspectors can carry out inspections of all places of employment and can target such places by sector or geographical area.

Overall, it would seem that while there will be an ongoing need to attract high-skills migrants from outside the EU, legislators believe a sufficiently buoyant internal labour market, of EU citizens, family reunification entrants and refugees, will exist to supply the necessary demand for low-skills labour. The emphasis in the case of non-EEA migration increasingly emphasises high-skills migrant labour only. It may indeed be the case the adequate sources of other migrant labour can be found within the EEA in the short to medium term. Indeed, the admission of Romania and Bulgaria to the EU was not accompanied by unrestricted entry to the labour market, indicating that countries such as Britain and Ireland believe there is already a sufficient supply of labour from the 2004 Accession States. But past experience would suggest that as the economies of central and Eastern Europe begin to grow many of their migrants will return home, as the Irish, Italians, Greeks, Spanish and Portuguese did in their day. Moreover, many European countries have fertility rates below that needed to replace the population, and so may not serve as significant future sources of labour migration. In the medium to long term it seems unlikely that internal EU labour movement alone will supply the needs of the labour economy once other member states open their labour markets and economic convergence, as has been argued, reduces the incentive to migrate in the first place. In the meantime the emerging distinction between an attractive regime for high-skills

migrants and an unattractive one for low-skills migrants would seem to open the door to a new form of revolving-door *gastarbeiter* migration.

Finally, Ireland has not yet introduced a points-style policy for the management of high-skills immigration, as has been the practice in many mature immigration states such as the US, Canada and New Zealand. With the introduction of such a system by the UK it seems likely that Ireland will follow suit. Such an approach may, for instance, enable managed migration in sectors such as older adult care to be more effectively fine-tuned and to take account of projected growth in demand – but again this is likely to be only focused on high-skill labour migrants.

Visa Stamps and Long-term Residence

Like many countries, Ireland operates a system of immigration stamps, which are issued in conjunction with a Certificate of Registration by the Garda National Immigration Bureau (GNIB) as evidence of a non-EEA citizen's permission to be in the country. All non-EEA nationals must register with the GNIB after arriving in the country. The primary immigration stamps are listed below.

- *Stamp 1*: permits a person to remain in Ireland for a specified time and allows that person to enter employment on condition that he/she holds a valid employment permit (e.g. work permit or green card).
- *Stamp 1a*: permits a person to remain in Ireland for a specified time for the purpose of full-time training.
- *Stamp 2*: permits a person to remain in Ireland for a specified time to pursue a course of study on condition that the person does not engage in employment for more than 20 hours a week during term time.
- *Stamp 2a*: permits a person to remain in Ireland for a specified time to pursue a course of study on condition that the person does not engage in any form of employment.
- *Stamp 3*: permits a person to remain in Ireland for a specified time on condition that he/she does not engage in employment.
- *Stamp 4*: permits a person to remain in Ireland for a specified time and allows that person to enter employment without having to obtain an employment permit. People that can be granted a stamp 4 include refugees, spouses of Irish and EU citizens and people who have received long-term residency.
- *Stamp 5*: permits a person to remain in Ireland who has dual citizenship, one of which is Irish.
- *Stamp 6*: permits a person to remain in Ireland without condition of a specified time.

To obtain long-term residency a person with a work permit must have lived and worked in Ireland for five years (i.e. 60 months) or more. An application can then be made to the Department of Justice, Equality and Law Reform requesting long-term residency. If long-term residency is granted, the GNIB will then change the stamp 1 on the person's passport to a stamp 4, entitling that person to work in Ireland without an employment permit for a longer period (5 years). Although it is intended that there is a more direct pathway to long-term or indefinite residence for individuals on green cards, this will not come into effect until the *Immigration, Residence and Protection Bill 2008* is enacted – thought to be later this year. This pathway will also apply to work permit holders. In the meantime, individuals with expired green cards can apply for a 'stamp 4 permission

of one year's duration', which entitles the holder to work without a permit during that time.

For those people who want to apply for Irish citizenship by naturalisation, they must have had a period of 1 year's continuous reckonable residence in the state immediately prior to the date of application. The person must also have 4 year's reckonable residence amounting during the 8 years prior to the 1 year's continuous residence. Those individuals who are resident in Ireland for 8 years or more can apply for a stamp 6 giving them leave to remain in Ireland indefinitely. It is expected that some of the immigration stamps will be reformed under the *Immigration, Residence and Protection Bill 2008*. (Irish Naturalisation and Immigration and Service, 2009^a; Irish Naturalisation and Immigration and Service, 2009^b; Migrant Rights Centre Ireland, 2009).

As presented in Table 2.1 of Chapter 2, the majority of non-EEA participants in this research are currently on an employment permit (i.e. work permit or green card- equivalent to a stamp 1) or on a stamp 4. Participants on a stamp 4 would include those who entered Ireland as asylum seekers, and those who worked and lived in Ireland on a work permit/work authorisation/work visa for more than 5 years. Care assistants currently on work permits would have entered under the old system, prior to changes made under the *Employment Permits Act 2006* (e.g. €30,000 salary requirement).

Employee Protection: Regulations, Enforcement and Support

Aside from certain protective elements built into the employment regulations for hiring migrant workers, there are no specific regulatory structures in Ireland for the protection of foreign national workers. There are, however, several general but relevant regulatory standards that aim to protect the rights and entitlements of an employee. These regulatory standards are supported in statute by a variety of employment legislation, which includes the *Industrial Relations Act 1946-2001*, *Protection of Employees (fixed-term work) Act 2003*, *Terms of Employment Act 1994* and the *Unfair Dismissals Act 1977-2007*.

In addition to the Employment Appeals Tribunal, the Labour Court and the civil courts, there are two bodies that investigate breaches in employment legislation on behalf of employees. The first is the Rights Commissioner Service, which operates as a part of the Labour Relations Commission. The Rights Commissioner investigates disputes, grievances, and claims on behalf of an employee or group of employees through participation of an employee and employer in a hearing. The second body (and as mentioned earlier) is the National Employment Rights Authority (NERA), which is an office of the Department of Enterprise, Trade and Employment. NERA will be established on a statutory basis under the *Employment Law Compliance Bill, 2008*, but at the time of writing NERA has no legislative basis. The NERA inspection services enforce aspects of employment legislation that include working hours, national minimum wage, and protection of employment for both Irish and foreign national workers. As a part of its remit NERA targets specific industry sectors, but has yet to focus on the health and social care sector. NERA inspectors have the power to enter premises on the basis of a complaint.

The remit of NERA also extends to private dwellings provided that the latter belongs to registered employers. The difficulty then is not only identifying any breaches in employment legislation in a private setting, but if the employer is not registered, then the employee can be in a very isolated and vulnerable position. A study by the Migrant Rights Centre Ireland (2004) into the experiences of migrant domestic workers noted the potential for racism and other discriminatory behaviour in home employment settings.

As a consequence of circumstances such as this, and as a part of the Towards 2016 social partnership agreement, the Labour Relations Commission in consultation with various stakeholders drafted a '*Code of Practice for Protecting Person's Employed in Other People's Homes*' in May 2007. The Code does not have a legal basis.



However, it does encourage the adherence to relevant employment legislation and sets out good practice with regard to employment standards (e.g. rates of pay, hours of work and list of duties). The Code is particularly important for migrant domestic workers, as it marks the first step in addressing the complexity of working and living in a private home of an employer.

Under the *Employment Equality Acts 1998 & 2004* and *Equal Status Acts 2000-2008*, an employee can bring a complaint in relation to discrimination to the Equality Authority. The Equality Authority is a quasi-autonomous state organisation that provides advice and support to a person bringing a claim to the Equality Tribunal, which then hears or mediates the claim. In 2007, 69% of the Equality Authority case files on the Equal Status Acts involved allegations of discrimination against public sector government departments, state agencies, local authorities, health agencies and schools. Almost 20% of case files under the Employment Equality Acts were filed on the grounds of racism, which was the second highest case file classification (Equality Authority Annual Report, 2007). Data is not available on the number or proportion of such complaints arising in the older adult care sector.

In a recent analysis of case files on abuse of employment rights, the Migrant Rights Centre Ireland (MRCI) identified key points that required reform. The MRCI (as documented in the 2006 Animate/NCCRI conference report on 'Promoting Rights of Migrant Workers') found that there were a lack of investigations by the Labour Relations Commission into these claims and a lack of provision of interpreters by the Equality Tribunal and similar statutory and semi-statutory bodies. The analysis also found that Labour Inspectorate inspections were often only superficial. But this finding was prior to the establishment of the NERA inspection services, which has taken over responsibilities of the Labour Inspectorate and has increased the numbers of inspectors available. The MRCI also note that these issues were compounded further by the concentration of migrant workers in sectors with substandard practices, and a lack of political will to address such practices.

Integration Policy

Integration today is a highly contentious topic. Some countries, such as France, favour an assimilationist approach: that migrants should become 'more French than the French themselves'. Others, such as the UK and the Netherlands, have favoured a more 'multicultural' approach, with recognition of cultural diversity. In the strict legal sense, multiculturalism has really only been applied in Canada and Australia (Mac Éinrí 2007).

Recent events, such as the riots in Britain in 2002 and the London suicide bombings of July 7th 2005, the 2005 riots in France, and the murders of Pym Fortuyn in 2002 and Theo Van Gogh in 2004 in the Netherlands, as well as the backlash from 9/11 in the US, have suggested to some critics that all is not well with the multicultural model. Some oppose it on the grounds that certain minorities – many would instance fundamentalist Muslims – allegedly cannot be accommodated within the western liberal democratic model. Others argue against multiculturalism for an entirely different reason, holding that it encloses individuals within communities and ghettoises them, making integration more difficult by emphasising communal rights over individual ones. In this perspective, the 1998 Belfast Agreement exemplifies an approach where an emphasis on 'parity of esteem' not only failed to attend to underlying issues of power and inequality, but arguably made the gulf between communities deeper than before by refusing to recognise the more complex and hybrid nature of many people's sense of identity, not easily pigeonholed into preconceived categories.

Whether one takes a pro- or anti-multicultural position, European countries have in general failed to deal with a deeper issue: a chronic underlying racism. In France a rhetoric of republican equality masks a reality of systematic discrimination in the workplace and society in general: mainstream French television station TF1's

first black news presenter started work only in July 2006. In Britain, which has done much more than France to promote equality and integration, there remains a subtle and sometimes hidden problem of discrimination, most obvious when class, gender and ethnicity intersect. Although many Commonwealth immigrants came to Britain with notions of the 'mother country' and a strong desire to be integrated, the British educational system, notably, let down their children and their children's children, creating chronically marginalised Black populations across the midlands and in other cities. This has led to a phenomenon of 'parallel lives' where mutually alienated communities live side by side but have little interaction. Nowadays the UK uses the term 'social cohesion' to imply a shift in emphasis from a commitment to diversity towards an approach stressing the necessity for communities to interact across the diversity boundary. Critics argue with justification that this can ignore the racialised nature of the state itself (e.g. MacPherson, 1999). Similar criticisms have been made of the Irish state's role (Lentin, 2004).

Behind much of the criticism of multiculturalism in Europe today there lies a dangerously simple idea – dangerous, because in this field nearly all simple ideas are wrong. This is the neo-conservative notion that people can really only empathise with those 'like us' – we will pay taxes, for instance, an expression of solidarity and a commitment to a social 'safety net', only as long as we think that 'the community' shares the same identity and attitudes as ourselves (Goodhart, 2004). This commitment to a primordial or tribal identity is of course deeply embedded in human history. But to erect it as a principle for the 21st century is to deny centuries of progress towards a civil society which embraces all, irrespective of origins, gender or belief. No-one would argue for a return to a world where women were denied the vote or children had no rights, nor would we accept that misogyny, sectarianism or open racism was justifiable.

Irish Approaches to Integration?

In 1999 the Department of Justice, Equality and Law Reform commissioned a report entitled *Integration: a two-way process* (Department of Justice, Equality and Law Reform, 1999). This is the only official report to date on the subject of integration and gives an indication of official thinking in this regard, even though it only applies to refugees and people with leave to remain and does not thus concern labour migrants and their families. The working definition of integration adopted by the report was as follows:

"Integration means the ability to participate to the extent that a person needs and wishes in all of the major components of society, without having to relinquish his or her own cultural identity."
(DJELR, 1999).

The report was produced at a time when Ireland's experience of immigration was new and relatively limited. It did not recommend 'hard targets' in achieving the aims set out and no public review or evaluation mechanism was put in place to monitor implementation of the report. There was little appreciation of the need for a more fundamental shift in attitudes, structures and services. It is not simply a question of making public services more user-friendly for migrants, but of the whole nature of the relationship between the migrant and Irish society in general.

National Action Plan against Racism (NPAR)

Matters advanced with the establishment in 1997 of the *National Consultative Committee on Racism and Interculturalism* (NCCRI) and the 2005 publication of the National Action Plan against Racism (Department of Justice, Equality and Law Reform 2005^b). Compared to *Integration: a two way process* this offers a more holistic

and comprehensive approach to anti-racism and integration and details an agenda for action in every area of statutory activity as well as the social domain more generally. However, it lacks a solid statutory basis for action, and the NCCRI lacked the status, budget or powers of its UK counterpart, the Commission for Racial Equality (CRE). Furthermore, under budgetary cutbacks announced in late 2008, the NCCRI was dissolved and ceased to function. This means that there is currently an absence of an independent expert body to provide advice and contribute to the development of policy and initiatives to combat racism. Although there is a growing recognition that the role of the voluntary sector is crucial, it has yet to be spelled out how precisely it will be involved.

The Intercultural Framework underpinning the NPAR is based on the following elements:

Protection: Effective protection and redress against racism.

Inclusion: Economic inclusion and equality of opportunity.

Provision: Accommodating diversity in service provision.

Recognition: Recognition and awareness of diversity.

Participation: Full participation in Irish society.

Appointment of Minister with Special Responsibility for Integration

In June 2007 the Government appointed Mr. Conor Lenihan (replaced in April 2009 by Mr. John Curran) as Minister for State with Special Responsibility for Integration. While it could not be said that Ireland has a fully fledged integration policy as yet, creation of a new ministerial portfolio is gradually leading to a more focused approach to the subject. In his first major policy statement *Migration Nation* (Diversity Ireland, 2008), the Minister has announced the creation of a Commission on Integration, based in its structure on the existing Forum on Europe, which will be drawn from appropriate academic and professional sectors and will engage in a series of public consultations as well as advising the Minister. A Ministerial Council on Integration, drawn from ethnic communities is also to be created.

Policy Challenges for the Future

Ireland faces a number of challenges, which may be divided into two key areas:

- Managing migration
- Achieving integration

Both policy areas will have to be developed within a framework which takes due account of Irish political, social and economic conditions, the constraints of a 'special relationship' with Britain and Northern Ireland, embodied in the Common Travel Area Arrangement, as well as evolving EU policy and migration trends at European and global level. New legislation, policy and institutional arrangements will be needed.

Managing Migration

The Government was probably initially caught unawares by the scale of changes in immigration to Ireland in the late 1990s. Moreover, initial attention, in political, media and public discourses, was very largely focused on the rise in asylum seekers arriving in Ireland at that time, to the extent that for several years there was little debate about labour migrants and their families.

Asylum Seekers and Refugees, and Immigration Generally

Government policy towards asylum seekers has been based on a frequently asserted belief that the majority of them do not meet the criteria set down in the 1951 Refugee Convention. The policy has sought to accommodate those awaiting a decision in reasonable conditions while expediting the procedures for processing claims, increasing the number of deportations and using a range of legislative and policy changes (e.g., carrier sanctions, or fines on transport companies) to bring about a stated aim of reducing the overall number of asylum seekers arriving in Ireland in the first place.

Key developments included:

- The Refugee Act 1996, which incorporated the 1951 UN Refugee Convention into domestic law for the first time and replaced an ad hoc system with a more formal and transparent structure although critics argued that it fell far short of best international practice.
- The establishment of the National Consultative Committee on Racism and Interculturalism (NCCRI) in 1998, after the European Year against Racism the previous year, and the Irish Human Rights Commission (IHRC) in 2001 following the 1998 Good Friday (Belfast) Agreement (Human Rights Commission Act 2000).
- The twin policies of dispersal and direct provision, implemented at the end of 1999, aimed at addressing a developing accommodation crisis in the Dublin area. Policy and practice currently obliges asylum seekers to stay in designated accommodation in various parts of Ireland, where they receive food and board and a small allowance, while awaiting a decision on their case. The necessity to address the accommodation crisis was not in dispute, but there has been criticism of the manner in which the system has been operated.
- Non-binding public consultation procedures on immigration were undertaken by government. The first Public Consultation Procedure on Immigration Policies took place in June 2001. The on-going social partnership process and direct submissions to, and meetings with, ministers and politicians constitute the main mechanisms through which stakeholders can convey their views.
- A landmark Supreme Court judgement of 2003 struck down existing case law under which the parents of a child born in Ireland could usually obtain indefinite leave to remain. The Government argued that this had become an incentive to asylum seekers to come to Ireland.
- The *Immigration Act 2003* was passed: its main features include carrier liability provisions and updated arrangements for the removal of 'non-nationals' refused entry. The Act also made significant changes in the asylum system (including the 'safe country of origin' concept, allowing for the fast-tracking of applications from people not considered to be at risk if they are returned home).
- As a result of a High Court judgement in January 2004, the *Immigration Act 2004* replaced the bulk of the Aliens Order 1946; it placed on a firm footing the derived Ministerial authority of immigration officers when carrying out their functions.
- A citizenship referendum took place in June 2004. It removed the automatic right of citizenship for all those born in Ireland.

- A scheme was subsequently introduced which in effect regularized the vast majority of parents of Irish-born children who had been left in legal limbo by the 2003 Supreme Court decision.
- The Irish Naturalisation and Immigration Service (INIS) was established in 2005 with the intention of creating a 'one stop shop' for migrants in Ireland. Integration was to have been a part of the INIS brief but would now appear to have passed to the new Minister's office.
- In December 2008 the *National Consultative Committee on Racism and Interculturalism* was closed due to government cutbacks.

Towards a More Efficient and Better-Managed Policy

The claim has frequently been made by successive Irish Governments that Ireland's migration regime is one of the most open and flexible in the EU and beyond. Insofar as it is market- and employer-driven, it has proven relatively fast and responsive and has enabled the economy to cope with a prolonged period of rapid growth. However the piecemeal nature of policy changes, the lack of any long-term integration policy, and the public concern regarding well-publicised cases of exploitation have led to a recognition that a more comprehensive and durable regime is needed. Concern has been expressed by the social partners (employers as well as trade unions) about the absence of transparent regulations about such questions as family reunification and the absence of a path to permanence (other than citizenship) in Ireland's current immigration regime.

While the asylum situation is exceptional, it cannot in fairness be said that Government has adopted an anti-immigrant position in general. The importance of immigration to the economy has been generally stressed and recognised, although the prevailing emphasis on high-skills migrants has not been matched by a commensurate concern for other migrants or their families. Some critics take a harsher view and argue that Ireland is operating a regime which, in *de facto* terms, is discriminatory in terms of country of origin, skill levels and a general unwillingness to accept the 'other' in Irish society.

In addition to state intervention, a strong landscape of vibrant organisations has emerged in recent years. There is now a range of non-governmental organisations (NGOs), which engage in advocacy and support as well as service provision for migrants and new communities in Ireland. Migrants themselves are now organising and a strong MELO (migrant and ethnic led organisation) sector is emerging. Integrating Ireland, an independent network of such organisations, lists over 180 groups that have the explicit aim of 'working in mutual solidarity to promote and realise the human rights, equality and full integration in Irish society of asylum seekers, refugees and immigrants' (Integrating Ireland, 2008).

Broader Horizons

As already suggested, Ireland is constrained to a very significant degree by the Common Travel Area (CTA) between the UK and Ireland, which allows for movement without passports for UK and Irish citizens between the two jurisdictions (Mac Éinrí, 2002). The desire of the UK authorities to retain an autonomous immigration control regime, for instance, has meant that they have not joined the 'Schengen area', an EU-wide area of free movement and common controls. Ireland has been obliged to follow suit.

The maintenance of the CTA requires a strong element of policy alignment on immigration matters. Since the conclusion of the Amsterdam Treaty in 1997, there has been progress towards the creation of a common EU migration policy. But, as already mentioned, Ireland and Britain do not participate fully in this process and have chosen to 'opt in' on a case by case basis. The Irish position is to participate to the extent that is

consistent with the maintenance of the CTA with the UK. It is possible that at some point in the future Ireland and the UK will become full participants in EU action in the field (Department of Justice, Equality and Law Reform, 2005a).

It may be asked whether Ireland's 'opt-out' is a position of principle or a pragmatic reflection of its close geographical and historical relationship with the UK. There can be no doubt that a significant and consistent element of British thinking about border control has been an unwillingness fully to accept EU policy because it would mean to some extent relinquishing control of UK borders in favour of a pooled arrangement. Britain, like Ireland, has historically monitored the movement of persons by monitoring its borders, not by monitoring people in the places where they live. This has always been a more feasible and effective approach for island jurisdictions.

Irish and British attitudes are regarded as anomalous by other EU member states and by the European Parliament. The British attitude may evolve over time, particularly if national identity cards (something which was opposed by successive governments up to now) are introduced. As far as Ireland is concerned, there would not appear to be the same position of principle as found in the UK case, but the government has made it clear on many occasions that the preservation of the CTA (presumably for as long as both governments deem it necessary) must take priority.

Ireland is also obliged to comply with its human rights obligations under international law, but to date (in common with its EU neighbours) has not ratified the United Nations or International Labour Organisation conventions on the rights of migrant workers.

Conclusion

Ireland is no longer a country where immigration can be regarded as a short-term or transient issue. The country has now definitively joined the European mainstream as a society where a population of mixed ethnic backgrounds will be the norm. A number of features concerning these immigration flows are worthy of note. First, immigration to Ireland has followed the classic two-tier pattern, with a strong demand for high-skills migrants in certain sectors such as medicine and high technology and a substantial flow of migrants into unskilled or relatively unskilled sectors. But, as pointed out earlier, such flows are in fact more complex than the two tier model suggests. Many migrants doing lesser-skilled work actually have high levels of qualifications. In the older adult care sector, this is exemplified by the phenomenon of qualified medical staff being employed in a capacity which is not commensurate with their expertise.

Second, initial strong flows of refugees and asylum seekers from the mid-1990s have significantly reduced, while labour migration from EU accession countries has increased dramatically. While the economy is currently experiencing a relative downturn and world economic prospects are uncertain, medium term indications suggest a resumption of relatively high ongoing levels of immigration over time. Such migrants are increasingly likely, over time, to come from outside an expanded EU (Turkish accession, were it to happen, could change such assumptions).

Third, the geographical spread of migrants in Ireland is highly dispersed, with almost all parts of the country experiencing some in-migration. This is particularly marked in areas such as social care.

Fourth, the range of source countries is highly diversified, although Central and Eastern Europe have been dominant and there has been a further significant shift towards the new accession countries since 2004. Most of the source countries have few previous close political or cultural connections with Ireland, posing an additional

challenge for migrants arriving here as well as for the receiving society. By the 2020s it is likely that migrants and their descendants will number up to one fifth of the population. Fundamental choices have yet to be made about how the process of integration should be managed.

Finally, Ireland does not, as yet, have a finely tuned labour market immigration policy. It appears almost inevitable, however, that in the case of non-EEA immigration the country will follow the broad outlines of UK thinking in this field, with an increasing emphasis on points-based systems instead of the market-led approach which has been followed heretofore.

Migrant Carers and Older Adult Care: Projections of Future Need



“Additional demand for migrant care workers will not only arise from an ageing of the population, but also due to a change in the role that families will play in caring for older people in the future.”

Introduction

Following on from the previous chapters on the older adult health and social care sector and the migration environment, this section explores the future human resource needs and in particular the need for migrant nurses and care assistants for the care of older people in Ireland. We use population projections to derive projections of the numbers of formal health and social care workers needed in Ireland out to 2035. Having produced estimates of the numbers of health and social care workers needed, we go on to estimate how many of these will be migrant workers.

Ideally, we would like to provide separate projections for the health care and social care systems but this has not been possible. The most reliable source of data for the numbers currently employed in these areas comes from the Central Statistics Office (CSO) and they do not provide this health care/social care breakdown. Only information on the number of ‘nurses and midwives’, ‘nurse’s aides’ (taken to be close to or equivalent to care assistants) and ‘care assistants and attendants’ is available. In the projections below, these groups are aggregated into one and labelled ‘care workers’. Hence, in the rest of this section reference to care workers should be understood as covering this group, some of whom will be working in the social care sector. It would also have been desirable to have information on what proportion of care workers work with older people but, again, this information is not available. In our projections, we attempt to apportion healthcare workers across the younger and older populations.

Although our inability to consider the health and social care systems separately has its disadvantages, there are also advantages. As our analysis below involves projections over a period of almost thirty years, there is obviously a huge margin of error attached to the projections. By looking at categories of workers in more aggregated forms, we are hopefully reducing the margin of error and are certainly steering away from creating the false impression that we can project smaller categories of workers with any degree of reliability. It is this consideration that leads us away from considering nurses/midwives, nurses aides and care assistants separately, even though we do have this data. Over time, duties that are performed by nurses could be transferred to care assistants, whereby there would be a shift between the two groups in terms of numbers needed. By aggregating the two groups and providing long-run projections for them as a single group, such switching is removed as a concern from the analysis.

The chapter is structured as follows. In the first half of the chapter, we provide a brief overview of recent research findings on the characteristics and labour market outcomes of immigrants in general in Ireland. This is by way of providing a broader context for the specific discussion on the health and social care sector. We then go on to discuss the recent situation in Ireland regarding the efforts by the authorities to recruit foreign carers. The international situation with regard to the use of foreign national workers in the care sector is then reviewed. In the second part of this chapter we move on to the population projections, the associated projections of human resource needs in the health and social care sector and the extent to which these needs might be met through the recruitment of migrant workers. Finally, we summarise our analyses and offer some conclusions.

Before turning to the details of the situation in Ireland, it is important to address one further issue. The discussion and analysis in this chapter is based on the assumption that there will be health and social care sector labour shortages in Ireland in the future because of an under-supply of Irish care workers relative to demand. From the perspective of economics, this may seem like an odd assumption as there would be an

■ ⁷ This chapter has been written by Alan Barrett of the *Economic and Social Research Institute, Dublin* and Anna Rust of the *Irish Centre for Social Gerontology, National University of Ireland Galway*

expectation that any under-supply would lead to wage increases and hence an increased inflow into the sector. However, as discussed by Raghuram and Kofman (2002), the nature of the health and social care sector is such that the standard market mechanisms are unlikely to apply. As the provision of health and social care is dominated by the public sector, the provider of health and social care services (i.e. the state) is in a position to alter immigration rules so that any under-supply is met through the inflow of foreign workers, as opposed to wage increases. In addition, as the state has an incentive to constrain wage inflation in the sector, such foreign recruitment is likely to be attractive. For these reasons, it is reasonable to see development in human resource needs in the health and social care sector as resulting in increased inflows from outside of Ireland as opposed to wage increases and hence an increased inflow from domestic sources⁸.

The International Situation

Before looking at the specifics of health and social care, we should note that the Republic of Ireland is host to just a small fraction of the estimated 191 million international migrants in the world today (UN, 2006^a). However, the ratio of foreign nationals to the local population in Ireland is comparable to other industrialised countries. Ireland's proportion of 10.4% of foreign nationals exceeds that of its nearest neighbour the United Kingdom (8.3%) and is similar to countries with a longer history of immigration (OECD, 2007^b). For example, the percentage of foreign-born residents in the United States stands at 12.3%, while in Germany it has reached 12.5%. (NESC, 2006).

Europe as a whole is facing a demographic challenge characterized by declining fertility rates and a rapidly ageing population⁹. In recent years, these demographic and societal changes have contributed to significant, long-term labour shortages in the health and social care sector. In certain cases, where policy-makers have identified a shortage of care workers, one of the responses to the labour shortage has been to employ migrant workers. This offers a 'quick fix' which can be attractive to policy makers. It can take three to five years to train a nurse, and fifteen to twenty years to train an experienced senior physician (Stewart, Clark and Clark, 2007). Recruiting in other countries can deliver these staff much quicker and without the expense of education and training costs. However, this 'quick fix' leads to questions about the economic and social integration of migrant care workers and also about the impact on sending countries.

Almost every European country is experiencing a shortage of registered nurses (Stewart et al., 2007). For example, the UK had 57,000 fewer nurses than needed to staff the National Health Service in 2001. Australia faced a 40% shortage of nurses to fill open positions in 2006; by 2011 Canada could have a shortfall of 78,000 nurses. Virtually all developing countries suffer from a chronic shortage of nurses. The Philippines, the country from which the largest number of registered nurses migrate to developed countries had 30,000 vacancies for nurses in 2004. In 2003, Malawi reported that only 28% of nursing positions were filled; in the same year South Africa had a shortage of over 32,000 registered nurses. The best estimates indicate that, collectively, sub-Saharan African countries have a shortfall of over 600,000 nurses (Irish Council of Nurses, 2004).

English-speaking countries constitute the most popular destination in the global labour market for nurses. The Philippines supplies the largest number of foreign nurses to the United Kingdom, while South Africa, Nigeria and

■ ⁸ It could be the case that expansion of the health and social care systems will occur through the private system. Even if this is the case, it could well be the case that the government would come under pressure to ease immigration restrictions if the cost of such care was rising because of labour supply constraints.

⁹ With the highest fertility rate in the EU- 25, Ireland's demographic projections are positive compared with the rest of the region, and the country currently has less need of migration as a means of replacing the dwindling working-age population (NESC 2006). However, as will be seen in the subsequent sections this will change.

Zimbabwe, Australia, India and a number of Caribbean countries also provide significant numbers of registered nurses. The Philippines represents the greatest source of foreign nurses in the United States, followed by Canada, the Republic of Korea, India, and the United Kingdom. In 2001, about two-thirds of the new nurses registering in Ireland were from other countries, mainly Australia, India, the Philippines, South Africa and the United Kingdom (Stewart et al., 2007).

Receiving and Sending Countries: Policy Issues

As discussed by Buchan (2007^b), policy responses to shortages in the developed world have included 'fast tracking' of work permit applications, developing coordinated, multi-employer approaches to recruitment to achieve economies of scale in the recruitment process and developing multi-agency approaches to coordinated placement of care workers when they have arrived in the source country. These may include the provision of initial periods of supervised practice or adaptation, as is the case in Ireland, as well as language training, cultural orientation and social support to ensure that the newly arrived workers can assimilate effectively into the new country, culture and organisation.

The UK probably has the most systematic and coordinated recruitment programme of any country in the world. The British National Health Service (NHS) has its own recruitment programme to identify healthcare professionals interested in immigrating to the UK. It operates different recruitment strategies for the various professions. It usually recruits physicians on an individual basis, but tends to recruit nurses in groups of ten, twenty, or more from a specific country. As part of its recruitment process, the NHS provides information on job locations, living arrangements and immigration procedures (Stewart et al., 2007).

Ethical concerns raised about the impact of migration on developing countries have caused the national health services in the UK and Ireland to adopt ethical guidelines for the recruitment of overseas nurses. These guidelines require host agencies to provide accurate and truthful information to potential recruits about terms and conditions of employment. However, these guidelines do not apply to private healthcare facilities. Nor do they restrict public healthcare systems from hiring foreign nurses who migrate and apply for positions on their own initiative.

Another approach to regulating the migration of health and social care professionals is the signing of inter-country agreements that place limits on the number of professionals who can be recruited, thus minimizing the damage to the sending country's health system. In 2003, the National Health Service and the South African government reached agreement on an exchange programme entitling healthcare professionals of both countries to work in the other country for up to six months. Although the programme will probably bring more South African registered nurses and medical doctors to the UK than the reverse, the migration will be for a fixed period of time (Stewart et al., 2007).

In terms of policy issues for sending countries, the reasons why nurses and doctors might leave their own health systems include such factors as low wages, poor working conditions and poor career opportunities. Along with these factors, pull factors can also cause workers to migrate. For example, after adjustment for the cost of living, nurses' salaries in Australia and Canada are double those of nurses in South Africa, 14 times those in Ghana, and 25 times those in Zambia (Stewart et al., 2007).

But perhaps more of an issue is the damage that the loss of care workers can cause to an evolving health and social care system in developing economies. As developing countries generally lack the resources to train an adequate number of nurses in the first place, the loss of some of the stock of nurses exacerbates the problem

of providing adequate healthcare for citizens of the developing world. The fact that migrant health and social care workers send back remittances to the source country partially compensates for training/educational costs and damage to the health and social care system of the source country. However, remittances go to families, not directly to the health and social care system and thus the extent to which such monies serve as compensation is likely to be limited.

Immigrants in Ireland: Education and Labour Participation¹⁰

Starting with Barrett and Trace (1998), a number of papers have looked at the characteristics of immigrants in Ireland (Barrett et al., 2006; Minns, 2005). Barrett and Trace showed that immigrants in the mid-1990s were a highly educated group, with levels of education that significantly exceeded those of the native population. One of the hypotheses explaining this observation was that the immigrants of the 1990s were ‘early movers’ and may have had access to more information on Ireland. This gave rise to an expectation that the level of education among immigrants would fall as inward migration continued and increased.

The later analyses of immigrant characteristics continued to show immigrants as being a highly educated group, based on both the Quarterly National Household Surveys (Barrett et al., 2006) and the Census 2002 (Minns, 2005). It was also shown that immigrants had higher rates of labour force participation and higher employment rates. Barrett and Duffy (2008) did show that the level of education among immigrants was lower among the more recent arrivals. Even so, the most recently arrived cohort (as of 2005) still had higher levels of education than the native population.

On the issue of how migrants are performing in the Irish labour market, the evidence suggests that they do less well than the native population. Ruhs (2005) provided the first study on earnings but his data was limited to work permit holders and so omitted the many EU nationals who were living in Ireland at the time of his analysis. Barrett and McCarthy (2007^a) show that immigrants earned 18 per cent less on average relative to native workers using data for 2004, controlling for factors such as education and length of labour market experience. For immigrants from non-English speaking countries, this wage gap is 31%. Barrett and McCarthy also show that the wage gap is biggest for the more highly educated immigrants, relative to comparable native employees. Similar results are found in Barrett and McCarthy (2007^b), where data from 2005 is used.

The issue of labour market performance is also addressed in Barrett et al. (2006) and Barrett and Duffy (2008). As these papers use the CSO’s Quarterly National Household Survey (QNHS), the sample sizes are larger than that used by Barrett and McCarthy. However, as the QNHS does not include information on earnings, the analyses in these papers use occupational attainment rather than wages as a measure of labour market outcomes. Both papers show how immigrants are less likely to be in higher-level occupations, controlling for factors such as age and education, and label this as an ‘occupational gap’. Barrett and Duffy (2008) also show how this “occupational gap” is largest for immigrants from the EU’s New Member States and how the gap does not seem to decline for this group as they spend longer in Ireland. Based on this finding, Barrett and Duffy conclude that there is an absence of evidence of increased labour market integration of immigrants over time.

Regulations for Migrant Carers Working in Ireland

In addition to the immigration and employment regulations detailed in the previous chapter, migrant nurses must also satisfy other conditions to work in Ireland and to register with An Bord Altranais (the Irish Nursing Board). For nurse applicants trained in a non-EU country, who would enter Ireland on a green card, English

■ ¹⁰The discussion in this section is largely based on Barrett and McCarthy (2007b).

language competence is required at a level that supports communication and enables the applicant to practice nursing safely and effectively in Ireland. Therefore, proof of English language competence in cases where English is not the first language or primary language of expression of the applicant is required. Applicants must also have completed a programme of education and training of not less than three years duration and the programme must have had a balance of not less than one-third theoretical instruction and not less than one-half clinical/practical instruction (Irish Nursing Board, 2009^a). An Bord Altranais has introduced a competency-based assessment during the period of adaptation, involving supervised practice plus further education and training, if necessary. The adaptation period takes at least 6 weeks to complete, but it is acknowledged that most candidates can require up to 12 weeks to achieve the required competencies (Quinn, 2006).

If migrants have completed their nursing education and training in an EU member state the rules are different. In that case, they must attain certain qualifications/experience before entitlement to a direct registration with An Bord Altranais in accordance with EU Directives 77/452/EEC, 77/453/EEC and subsequent amendments, or the Act of Accession (Irish Nursing Board), which relates to the recognition of qualifications received in other member states.

In regard to care assistants, non-EEA nationals must apply for a work permit through the Department of Enterprise, Trade and Employment. To do so they must have a contract with an employer established in Ireland before an application for a work permit is granted and they must fulfill the other criteria outlined in Chapter 4, e.g. salary level. (Department of Enterprise, Trade and Employment 2007a and 2007b). On commencing work as a care assistant, and depending on the care setting, all migrant care assistants are also likely to be required to complete the FETAC level 5 training, as outlined in Chapter 3.

State Recruitment of Migrant Care Workers

The issue of labour shortages is a complicated matter and not all observers would agree that there are labour shortages in the health and social care sector in Ireland. This is particularly the case when discussing the case of registered nurses. The Irish ratio of nurses per 1000 population is 15.2 which is much higher than the OECD or EU15 average of 8.6 (OECD, 2007^c) and 8.5 (FÁS, 2005) respectively. It has been argued that Irish nurses spend time on tasks that could fall within the remit of other personnel such as care assistants as discussed above. There are therefore efforts to bring the duties of Irish nurses into line with other OECD health care systems (Quinn, 2006).

Ireland, historically a net exporter of nurses to countries such as the UK and the US, began in the 1990s to encounter nursing shortages. As a result, employers of care workers initiated international recruitment campaigns to facilitate the migration of qualified nurses to Ireland.

As discussed by Quinn (2006), the two public recruitment projects in relation to nursing in Ireland are (1) the HSE Nursing/Midwifery Recruitment and Retention National Project and (2) the Dublin Academic Teaching Hospitals (DATH) Recruitment Project. The HSE recruitment project has involved two recruitment drives. In 2005 nurses were recruited from the Philippines and India, while in 2006 the drive targeted only India. The selection of countries depends on the type of personnel needed in Ireland. The HSE has built up a relationship with the Philippines, so as to enable Ireland to attract more qualified nurses to come and work with older people if there are domestic shortages in the future.

In 2006, the Dublin Academic Teaching Hospitals recruitment project targeted India, Bahrain, Singapore and the Philippines. There is also substantial recruitment of nurses by private agencies into private institutions,

particularly from India. The DATHs project has recruited approximately 1,000 nurses since it was set up in 2001 in response to a shortage of nurses in the hospitals. Of that number, 507 were recruited in 2005 to fill the gaps resulting from the lack of domestic graduates caused by nursing changing from a three-year to a four-year course (Quinn, 2006).

Statistics from the CSO show that the proportion of migrant carers in the Irish workforce has increased substantially in recent years. While only 2% of the health and social care workforce were foreign nationals in 1998, this proportion had increased to 16% by 2006 (CSO, 2006^b). Between the years 2000 and 2006, 9,441 nurses were issued with Work Visas/Work Authorisation, of which 90% went to nurses from India and the Philippines. The total number of Work Authorisation/Work Visas issued to nurses accounted for 60% of all skilled professionals between the same years (Royal College of Surgeons in Ireland, 2008). The years 2001, 2005 and 2006 were years of particularly strong overseas recruitment. This correlates with the active recruitment projects by the DATHs and the HSE due to the lack of Irish nursing graduates in those years. In 2007, there were 4,329 Employment Permits issued under the 'Medical and Nursing' category.

Projections of Need

We now turn to the main issue of the chapter, namely, projecting the number of migrant health and social care workers that will be needed in the Irish older adult health and social care sectors out to 2035. We will begin this section by outlining how we arrive at the population projections that underpin our projections of the need for migrant care workers.

Population Projections

A number of scenarios are presented. As with all exercises of this nature, it is important that the results be seen as projections as opposed to forecasts. What we are providing is an estimate of how the health and social care sector might look, under certain (reasonable) assumptions. The population assumptions, concerning fertility, migration and mortality, used by the CSO in 2004 are adopted and applied to baseline data from the 2006 Census. The CSO present a number of scenarios based on three different fertility assumptions, two in the case of migration and one for mortality. Rather than presenting the full set of scenarios, we have chosen to restrict our analysis to one fertility assumption (the middle assumption, labelled F2 by the CSO) and two migration assumptions. This gives us two sets of projections, as opposed to the six that the CSO present. For the purposes of presentation, we will focus first on what we will call *M2F2*, where the following assumptions hold.

- **Mortality:** As would be expected, the CSO assume that mortality rates will decrease based on international experience and recent trends. The specific rate of increase is derived in the following way – it is assumed that the rate of improvement of mortality rates observed between 1986 and 2002 is maintained out to 2035. This implies a life expectancy for men of 82.5 years in 2035 and for women of 86.9 years. (The corresponding figures for 2002 were 75.1 years for men and 80.3 years for women).
- **Fertility:** The total fertility rate is assumed to decrease to 1.85 by 2011 and to remain constant thereafter. This assumption is based on several factors, including the increased educational attainment and labour force participation of women that are expected to exert downward pressure on fertility. The CSO label this assumption F2.

- **Migration:** Migration is the most uncertain factor affecting the population. It tends to be much more variable than the other components of population change and a failure to foresee the rapid inflow of recent years meant that projections from the earlier part of this decade generally underestimated the recent growth in Ireland's population. The migration assumption (CSO label M2) sees immigration continuing but at more moderate levels. The assumed rates of net inflow are 20,000 per annum between 2006 and 2011, 10,000 per annum between 2011 and 2016 and 5,000 per annum thereafter.

The CSO (in their 2004 exercise) apply these assumptions and arrive at growth rates for the population by age group and gender out to 2036. These growth rates are applied to the population in this exercise but starting from the base year of 2006 out to 2035. In Table 1, we present the results in summary form for the second migration assumption (M2) so that the broad picture of Ireland's changing population structure can be seen.

Table 5.1 Population projections, 2006-2035, under CSO migration assumption 2

M2F2	2006	2008	2013	2018	2023	2028	2035
Total population	4,239,848	4,277,445	4,520,619	4,712,423	4,856,493	4,969,546	5,102,841
Number of population over 65	467,926	485,966	567,609	668,791	779,568	904,744	1,089,967
As a percentage of total population	11.04	11.36	12.56	14.19	16.05	18.21	21.36
Number of population over 85	48,028	50,240	58,164	67,343	79,802	98,885	149,181
As a percentage of total population	1.13	1.16	1.29	1.43	1.64	2	2.92

Source: Own calculations based on 2006 Census data and CSO 2004 growth rates. NOTE: M2F2 = growth rates calculated on immigration of 20,000 per annum 2006-2011, 10,000 per annum 2011-2016 and 5,000 per annum thereafter, and fertility rate decrease of 1.85 by 2011 and remains constant thereafter.

A number of important points emerge from Table 5.1. First, the total population is projected to grow from 4.28 million in 2006 to almost 5 million in 2028, and to continue growing to over 5.1 million in 2035. In percentage terms, this implies a growth rate of 16.2 per cent between 2008 and 2028 and of 19.3 per cent between 2008 and 2035.

While these figures are interesting, it is the change in the age structure of the population that shows the more dramatic trends. Currently, 11% of Ireland's population is aged over 65 and, as such, Ireland does not yet share many of the age-related challenges facing other European governments. However, what is clear from the Table is that this situation will change quite substantially over the next twenty years and beyond. In terms of numbers, the population aged over 65 more than double in the period out to 2035. As a proportion of the population, the over 65s will account for over a fifth of the population in 2035. For those aged over 85, the trends are even more dramatic. Their numbers will essentially treble between now and 2035.

It will be seen in the next section that this increase in the population of older people essentially drives the projected increase in migrant care worker needs. In the absence of a changing population structure, some external recruitment of health and social care workers might be needed to replace exits among Irish care workers. However, the pattern that is revealed in the care workers projections is of increased need in these areas as a result of population ageing. When reading the results, it should be kept in mind that we are projecting workers in both the health care and social care sectors. It could be that population ageing will also be associated with the rise in the use of social care relative to healthcare.

Health and Social Care Worker Projections

The next step is to translate the population projections in Table 5.1 into possible demands for health and social care workers. Arguments can be made that the rate of growth in care workers will be above or below that of the population in general. For example, if productivity gains can be realised in the health and social care system, it could be that the rate of growth in care employment will be below that of the population. Alternatively, if health and social care has an income elasticity of demand that is greater than one, then the future growth in care employment could exceed that of the population if the income of the population is also growing. This exercise does not attempt to factor in either productivity growth or income elasticity effects.

The projections for care workers take account of the changing structure of the population and, in particular, the ageing of the population. The ageing dimension is factored in by drawing on a rule-of-thumb suggested by the OECD (1987) that people over the age of 65 consume four times as much healthcare as those under the age of 65. Essentially, what we do is multiply the population over 65 years by four. We add this number to the population under 65 to get the number of 'under 65 equivalents'. One way of thinking about this concept is to imagine a population, which place the same demands on health and social care but which was made up of under 65s only. We then divide the number of care workers currently employed by the number of under 65 equivalents to calculate the number of care workers per under 65 equivalent. To estimate the number of care workers working with the under 65s, we multiply the care workers per under 65 equivalent by the population under 65. The residual number of care workers provide an estimate of the number working with the over 65s.

The assumption of a continued ratio of health and social care usage across the over and under 65s of 4:1 is controversial. An argument is often made in the literature that health and social care consumption among older adults tends to fall in an ageing population because of reduced morbidity. We see this as being a reasonable argument, but for two reasons we remain with the 4:1 ratio. First, recent work in Ireland suggests that the ratio of hospital usage by those aged under and over 65 is 6:1 (HIPE and NRPS Units, ESRI 2002). This means that our 4:1 ratio may be conservative. Second, with falling family sizes and increased female labour force participation, it is likely that the amount of family-based care will decline and that this will be replaced by market-based care. This is not incorporated into the analysis. Given that these two factors would tend to increase the estimates of health and social care needs in an ageing population, their omission from the analysis should counterbalance the omission of improved morbidity¹¹.

The results of this exercise are summarised in Table 5.2. The first line of Table 5.2 shows the projections for the number of care workers that will be needed out to 2035. For 2006, figures from the CSO show that there are 94,261 health and social care workers in Ireland (nurses and midwives, nurse's aides etc. and care assistants and attendants). The 4:1 ratio implies that 31,261 of these are working with people over the age of 65 and 62,999 are working with the population under the age of 65. Given the rise in the population aged 65 and over shown in Table 5.1, it would be expected that we would see a large rise in the projected number of care workers working with older adults and this is evident in Table 5.2. By 2028, the number of health and social care workers needed for the over 65 group is 62,196. By 2035, the corresponding figure is 74,761. The growth in the number of care workers working with the under 65s is much lower and, again, this is unsurprising given the population projections.

■ ¹¹ This 4:1 ratio approach in projecting care demand has been used by Barrett and Bergin (2005) and by Barrett et al (2007)

Table 5.2 Projections of need for care workers, 2006-2035, under CSO migration assumption 2

M2F2	2006	2008	2013	2018	2023	2028	2035
Total number of care workers	94,261	97,337	105,639	113,789	121,754	129,986	141,598
Projected number of care workers working with over 65s	31,262	33,324	39,239	46,069	53,638	62,196	74,761
Projected number of care workers working with under 65s	62,999	64,013	66,400	67,721	68,116	67,790	66,837
Extra number of care workers for total population relative to 2006	0	3,076	11,378	19,528	27,493	35,725	47,337
Extra number of care workers for older population relative to 2006	0	2,063	7,978	14,808	22,377	30,935	43,500

Source: Own calculations based on projected population growth and 4:1 care usage ratio. NOTE: M2F2 = growth rates calculated on immigration of 20,000 per annum 2006-2011, 10,000 per annum 2011-2016 and 5,000 per annum thereafter, and fertility rate decrease of 1.85 by 2011 and remains constant thereafter.

In total, our projections suggest that the number of health and social care workers in Ireland will rise from 94,261 in 2006 to 129,986 in 2028 and to 141,598 in 2035. These figures translate into a growth of 38% in health and social care worker numbers by 2028 and of 50 per cent by 2035. As shown in Table 5.2, in terms of numbers of workers, our projections suggest that an extra 35,725 health and social care workers will be employed by 2028 and an extra 47,337 by 2035 for the total population, while an extra 30,935 workers will be needed by 2028 in the older adult care sector and an extra 43,500 by 2035. This represents an almost 100% increase by 2028 and 140% increase by 2035.

National/Foreign National Split in Care Worker Projections

The next task is to provide some indication of how the extra workers will be distributed by Irish national and foreign national employees. There are three approaches taken to the issue. As will be seen, the three approaches provide low, medium and high estimates of the numbers of migrant care workers required for the future.

In the first approach (which we label Scenario 1 or S1) we keep the amount of migrant care workers in 2006 constant and all new care workers are assumed to be Irish nationals. While this scenario can be viewed as an extreme, and a somewhat unlikely implication of the current economic decline, S1 does provide a lower bound estimate of the number of migrant care workers in the sector in the future.

The second approach (which we label Scenario 2 or S2) is to take the current split between Irish and foreign national carers in the sector and to assume that this ratio will continue to hold out to 2035 for the population as a whole. Figures from the CSO show that the national to foreign national ratio in the sectors under discussion for the total population is 84% national to 16% foreign national¹².

In the third approach (which we label Scenario 3 or S3) we keep the amount of Irish health care workers in 2006

■ ¹² Other sources suggest that a higher proportion of health and social care workers may be foreign. For example, according to the Irish Nursing Board 21% of nurses are foreign. In addition, the employer survey conducted as a part of this study found that there was a higher concentration of migrant care workers working with the over 65s than for the sector as a whole; the ratio reported was 31.6% foreign national to 68.4% national for the older adult care sector. As the figure we are using is at the lower end of range, our results can be viewed as providing a lower bound estimate of the current and future demand for foreign health and social care workers.



constant and all new care workers are assumed to be foreign national. Clearly all three scenarios are extremes, with the demand for new migrant workers more likely to lie somewhere between scenario 2 and scenario 3.

The results from our projections of the split between national and foreign national health and social care workers are shown in Table 5.3. In S1 the current stock of migrant care workers of 15,101 for the total population is maintained out to 2035, as is the current stock of migrant care workers of 5,008 for the older adult population. As can be seen from Table 5.3, assuming that all new care workers will be Irish nationals means that extra migrant care workers will not be required for the general and older adult populations.

Table 5.3 Projections of need for extra migrant care workers, 2006-2035, under migration assumption 2

M2F2	The Three Scenarios	2006	2008	2013	2018	2023	2028	2035
S1	Number (stock) of migrant care workers needed for total population	15,101	15,101	15,101	15,101	15,101	15,101	15,101
S2	Number (stock) of migrant care workers needed for total population	15,101	15,593	16,923	18,229	19,505	20,824	22,684
S3	Number (stock) of migrant care workers needed for total population	15,101	18,177	26,479	34,629	42,594	50,826	62,438
S1	Number (stock) of migrant care workers needed for older population	5,008	5,008	5,008	5,008	5,008	5,008	5,008
S2	Number (stock) of migrant care workers needed for older population	5,008	5,339	6,286	7,380	8,593	9,964	11,977
S3	Number (stock) of migrant care workers needed for older population	5,008	7,071	12,986	19,816	27,385	35,943	48,508
S1	Extra migrant care workers needed for older population relative to 2006	0	0	0	0	0	0	0
S2	Extra migrant care workers needed for older population relative to 2006	0	331	1,278	2,372	3,585	4,956	6,969
S3	Extra migrant care workers needed for older population relative to 2006	0	2,063	7,978	14,808	22,377	30,935	43,500

Source: Own calculations based on projected carer need and 3 scenarios of national/non-national split. NOTE: M2F2 = growth rates calculated on immigration of 20,000 per annum 2006-2011, 10,000 per annum 2011-2016 and 5,000 per annum thereafter, and fertility rate decrease of 1.85 by 2011 and remains constant thereafter. S1 assumes all new care workers out to 2035 are Irish nationals. S2 assumes current split of 16.02% foreign carers in the sector holds out to 2035. S3 assumes all new care workers out to 2035 are foreign nationals.

Under S2 (where the current national/foreign national split is maintained out to 2035), a total of 22,684 migrant care workers would be needed by 2035 for the total population and 11,977 migrant care workers would be needed from the older adult population. In percentage terms, this would imply an increase in the number of foreign carers of around 50% from 2006.

The picture looks somewhat different however when we look at S3 (where all the additional health and social care workers are foreign). Now we find that 62,438 migrant care workers would be needed in total by 2035; for 2028, the figure is 50,826. With just over 15,000 foreign health and social care workers employed in Ireland currently, these figures suggest that the number would have to increase by over 200% out to 2028 and by over 300% out to 2035. As can be seen from the table, the vast bulk of the extra care workers would be needed for the older adult population.

Conclusion

Exercises that seek to project outcomes twenty and thirty years hence are likely to be inaccurate due to the complex realities of the world that we live in. Hence, the projections above should not be seen as forecasts. However, they can be viewed as possible outcomes given the set of assumptions that we have made.

The projections suggest that, under certain assumptions, there may be a need to treble the number of foreign care workers (registered nurses and care assistants) in Ireland in the period up to 2035. The ageing of the population will be the driving force behind the increased demand for health and social care workers in the future. Although additional demand for migrant care workers will not only arise from an ageing of the population, but also due to a change in the role that families will play in caring for older people in the future. Caretaker potential is declining in the Irish population making it less likely that families will be able to continue caring in the way they have done for decades. Even if there is a continuous supply of Irish national health and social care workers, Ireland will undoubtedly rely on the support of foreign national health and social care workers in the future.

Ireland is already involved in external recruitment of nurses and has altered its immigration rules to assist in the process. However, European economies are experiencing population ageing and thus Ireland will have to compete to an increasing extent for foreign care workers. This of course may also push up wages, thereby exerting pull factors on indigenous workers, thereby reducing demand for migrant workers. Secondly, as developing economies achieve higher levels of income, the 'push factors' associated with migratory outflows may diminish. Generally, however, we expect demand for migrant workers in the health and social care sector to remain strong in Ireland, particularly as the economy recovers in the longer term.

Current Demand and Supply Environment



"I know that the skills are very important too, but sure if you haven't compassion for the person you're looking after, what good is it all... do ya know, if your not kind and that."

Nursing home resident speaking about what makes a good carer

"Although it's not really planned before I came to Ireland to mind the elderly for good. You know for a long time I think I only work for a year and then go to a hospital but then I realised, oh god, I love this type of job..."

Filipino registered nurse speaking about reasons for working in older adult care

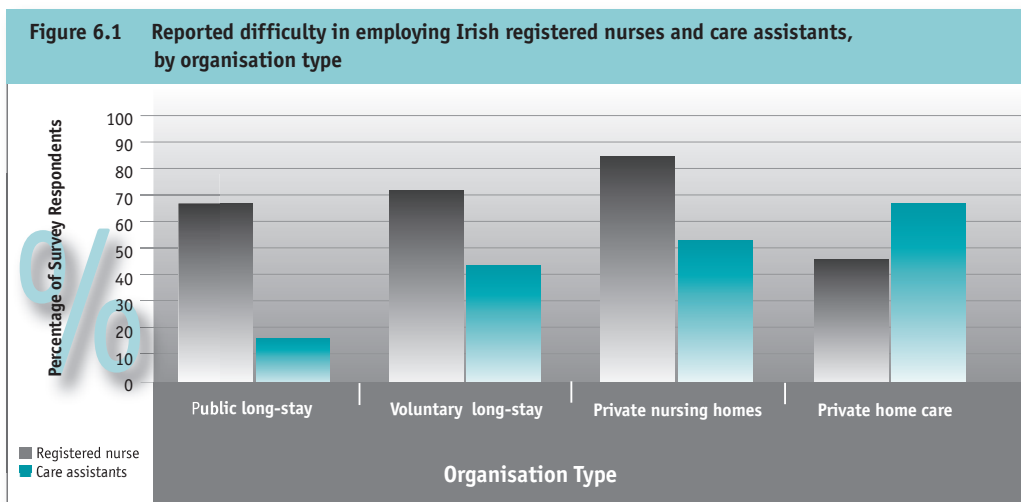
Now that the likely future need for migrant carers has been projected, this chapter explores in more detail some of the factors that influence the current demand and supply of migrant carers in the Irish older adult health and social care sector. The data for this chapter is drawn from the employer survey and telephone interviews, the migrant care worker interviews and the focus groups with older people. On the demand side, difficulties in hiring Irish carers are first presented followed by older adult preferences for care. With respect to supply, a current breakdown of the migrant care workforce in Ireland is provided; describing the sector and geographic distribution of the workforce and the principle countries of origin. Case-study data on two source countries is then presented followed by a description of the channels used to enter Ireland and the older adult health and social care type.

Demand

Domestic Market for Carers

Difficulties in recruiting and retaining Irish care workers contributed directly to the demand for migrant carers. Employers spoke about how the migrant labour force fulfilled a significant need that organisations had for workers. This was the unifying, and in many cases the predominant reason for employers to employ migrant carers. *“There hasn’t been availability of a local resource and in many cases they [migrant carers] 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.”*

Almost 80% of respondents to the employer postal survey reported having difficulty in employing Irish registered nurses, while 44% stated that they had difficulty in employing Irish care assistants. There is some variation with respect to organisation type and the level of difficulty experienced as illustrated in Figure 6.1.



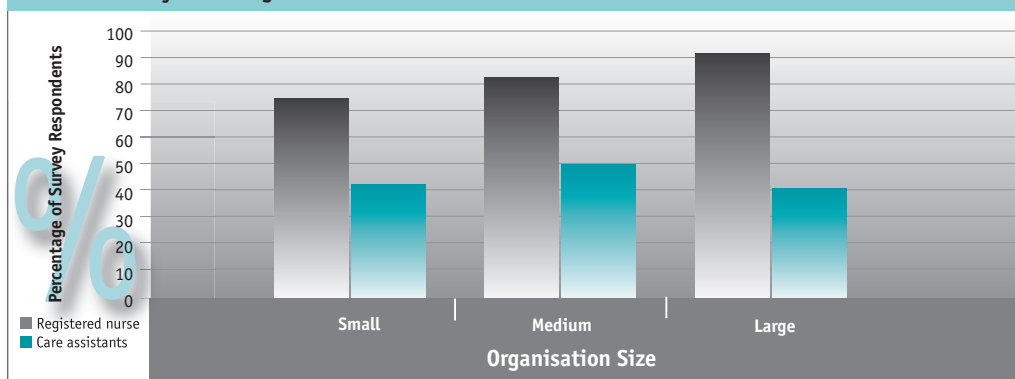
Source: Employer survey

NOTE: Public Long-stay = HSE extended care units, HSE welfare home, HSE district hospital and HSE community hospital; Voluntary Long-stay = voluntary geriatric hospital and voluntary geriatric home; all other categories as listed.

Private nursing homes reported the highest level of difficulty in hiring registered nurses, followed by voluntary long-stay facilities and public long-stay facilities. Private home care organisations had the least difficulty in hiring Irish registered nurses, but had the highest level of difficulty in employing Irish care assistants. This finding is likely to be a reflection of the social care (as opposed to medical care) orientation of home care organisations. Private nursing homes reported the next greatest level of difficulty in hiring care assistants, with public long-stay facilities reporting the least difficulty.

Large organisations had the most problems in employing registered nurses, followed by medium and then small employer organisations. Similar levels of difficulty were experienced across all organisation sizes in hiring care assistants (see Figure 6.2).

Figure 6.2 Reported difficulty in employing Irish registered nurses and care assistants by size of organisation

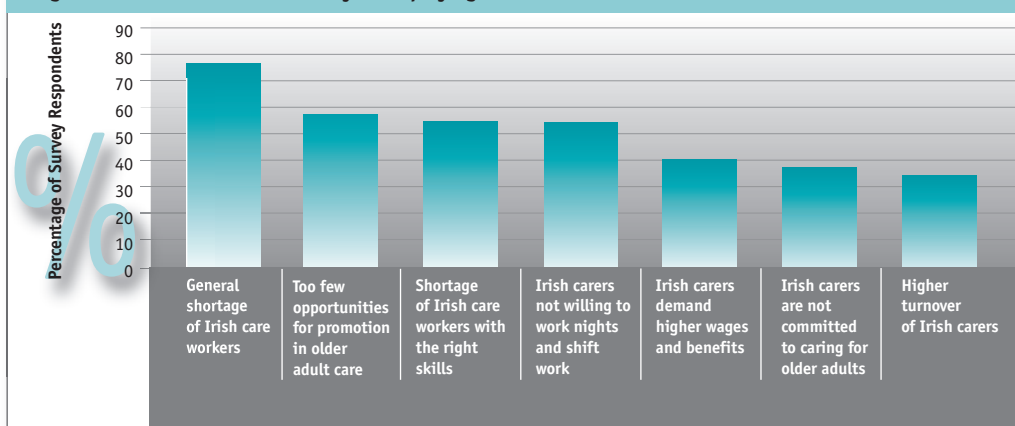


Source: Employer survey

NOTE: Small = organisations caring for 50 or less older people; Medium = organisations caring for 100 or less older people; Large = organisations caring for more than a 100 people.

Figure 6.3 shows that 77% of employers surveyed agreed that this difficulty arose from the general shortage of Irish care workers.

Figure 6.3 Reasons for difficulty in employing Irish care workers



Source: Employer survey

Other explanations chosen included too few opportunities for promotion in older adult care (58%), shortage of Irish workers with the right skills (55%), Irish carers not willing to work shift (53%), workers demanding higher wages and benefits (40%) and Irish carers not being committed to caring for older people (38%). According to employers, higher turnover was the least likely reason for the difficulty in employing Irish care workers. Nevertheless, almost a third of respondents still agreed that high turnover was a factor.

Responses to an open question on additional difficulties expanded on these issues. Some employers again focused on the general shortage of Irish carers, *“I recently interviewed for nurses [and] out of 120 applicants there were 4 Irish applicants”*. Other comments centred on ancillary concerns such as availability and dependability of the Irish labour force, *“[Irish carers] do not want to work weekends or shifts and do not want to work full-time.”* More critically, *“One cannot depend on Irish nationals in this present age, am speaking generally, as I try to employ local Irish [nationals] and have been let down, with some of them not even turning up to start work.”* Employers from private nursing homes also highlighted the difficulty in competing with the public sector for staff, which is a reflection of the findings presented in Figure 6.1. *“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.”*

The employer telephone interviews broadly supported the survey results. The general shortage of Irish care workers was the predominant reason for hiring foreign nationals. *“We need a certain amount of staff and it’s absolutely impossible. We’ve put numbers of ads in all the local media, paper, shops, everywhere and we cannot find any alternative [to migrant carers].”* While this shortage was mostly related to registered nurses, those organisations that primarily hired care assistants (e.g. home care sector) also expressed difficulty in recruiting Irish workers – again, as evident in Figure 6.1. Interview participants mentioned that potential applicants often opted for other low-skilled jobs that were less demanding and better paid. *“With regard to care assistants... I suppose they perceive it to be bottom of the line and it would be one of the lower paid jobs.”* However, a number of employers had mentioned that in the past year it was becoming easier to recruit Irish care assistants. Employers credited this reinvigorated labour pool to the recent economic decline that has strongly hit other sectors. *“The market here is squeezed a little bit with the downturn in the economy, so there’s more people available and when I put an ad in the local papers, I get many people calling... [many] Irish”*.

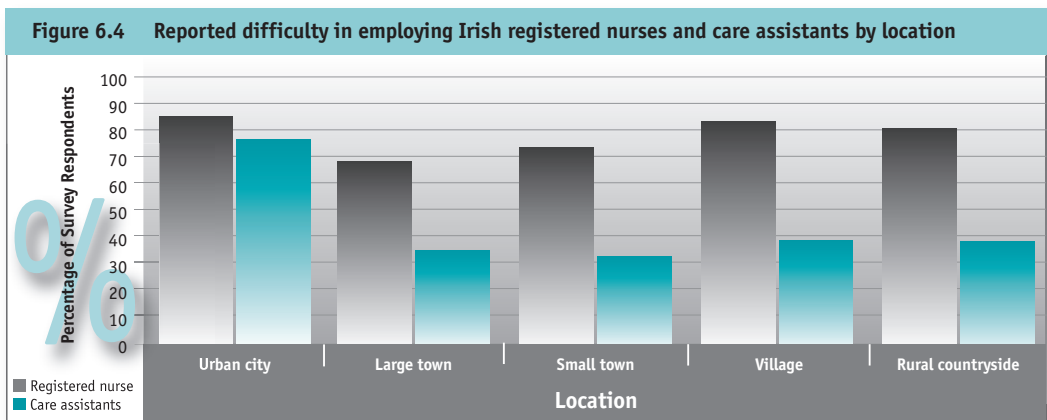
For registered nurses, employer interviewees stated that there appeared to be a preference to work in what are perceived to be more glamorous and prestigious positions within the health and social care sector, e.g. accident and emergency. Employers were also aware that increasingly many Irish nurses were deciding to go abroad, or into the pharmaceutical industry; partly for experience and remuneration and partly because of the recruitment restrictions in public facilities. This was outlined by one director of nursing in a community hospital. *“A lot of Irish nurses travel abroad to Australia, get experience and come back. But a lot of them are not coming back to work in the health service... they are going to work in pharmaceutical firms or branching out into different areas.”* As illustrated in the concern of one nursing home proprietor, nursing graduates appear to rarely consider the older adult care sector for employment, even when faced with difficulty in acquiring a job. *“We were in with something like 120 student nurses who were about to qualify and no jobs for them. And yet none of them thought about coming to work in a nursing home.”* This comment also refers to participants’ broader concerns about the negative perceptions of working in older adult care and the lack of career opportunities within the sector.

More generally, employers highlighted that Irish carers do not want to work full-time hours or shift work. For that reason, finding appropriate staff numbers was very difficult. *“a lot of Irish care staff would not be*



available to work full-time, they wanted to work two days a week, or one day a week or didn't want to work weekends, didn't want to work evenings." One employer questioned the commitment of some Irish carers to caring for older people. *"This type of work; not many Irish people want to do it."* While another interviewee noted that because of sick-leave, absenteeism and turnover, Irish carers were not a dependable workforce. *"Most of the difficulties I have with staff would be around Irish care workers... absenteeism, sick leave... I have had to let people go."*

Finally, the geographical location of an organisation appeared to serve as an added barrier in staff recruitment. As evident in Figure 6.4, organisations in urban areas (84%) have the greatest difficulty in hiring Irish registered nurses, followed closely by villages (81%) and the rural countryside (80%). Organisations in small town and large town settlements report the least difficulty in hiring Irish nurses. Employers in cities express, by far, the most difficulty in hiring Irish care assistants (76%), followed by villages (39%) and the rural countryside (38%). These findings would suggest that there is a more complex interaction between labour demand and place than may have been expected. The problems in rural recruitment is evident in the comment of one employer from the West of Ireland, *"There are no Irish nurses willing to work with older people in a very remote part of Ireland... so it's very hard to get qualified nurses... a lot of nurses think there is no advancement for them [in regions such as this]."*



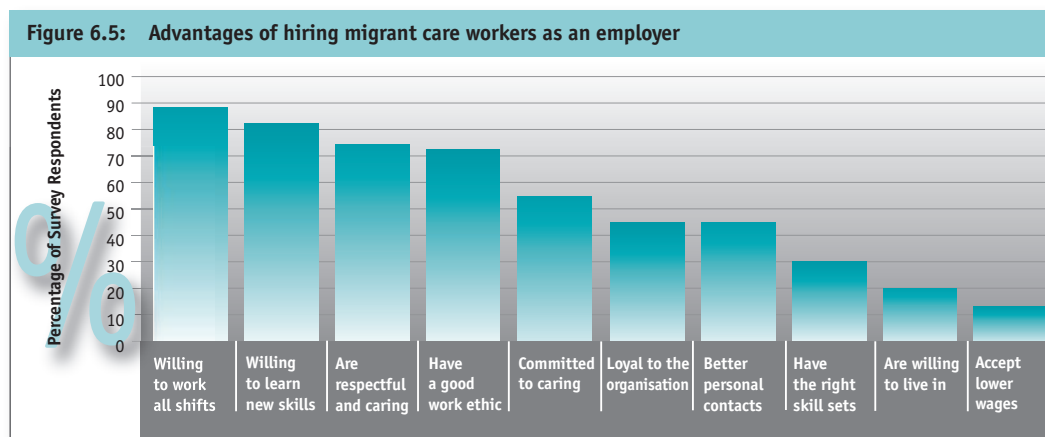
Source: Employer survey

Advantages and Challenges of Hiring Migrant Care Workers

This section presents the results of the employer survey on employer perceptions of the advantages and challenges of hiring migrant carers in the older adult health and social care sector. Perceived advantages and challenges of employing migrant carers are likely to influence employers' demand for foreign national care workers and are thus fundamentally linked to migrant carers achieving labour market integration. Some of the key advantages (e.g. work ethic and commitment to caring for older people) and challenges (e.g. language proficiency, culture and government regulations) are discussed in detail in Chapter 7 and Chapter 8, when the experiences of migrant care workers and older adults are explored in greater depth.

Advantages

Almost 90% of employers agreed that foreign national workers were willing to work all shifts (Figure 6.5). Four out of five respondents saw merit in the fact that migrant care workers were willing to learn new skills. Seventy two per cent of respondents stated that migrant care workers were respectful and caring towards older people, with 71% stating that migrant carers have a good work ethic.



Source: Employer survey

Accepting a lower wage was not highlighted as an advantage of employing migrant carers, with only 10% of employers stating that it was an advantage. Indeed, over 60% of employers surveyed indicated that migrant care workers do not accept a lower salary than Irish carers.

The advantages of employing migrant carers were generally common across all organisation types. That said, overall public long-stay institutions were less likely to agree with the list of advantages than the other organisations. Conversely, private nursing homes were more likely to agree with the statements. Differences in responses across organisation size were less clear, with no obvious pattern evident.

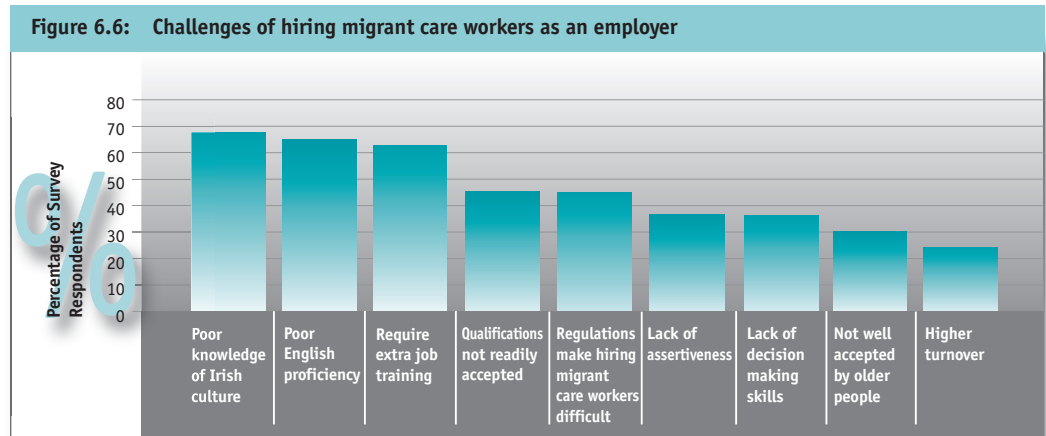
Challenges

Poor knowledge of Irish culture was considered by 68% of employers to be the most challenging aspect of employing migrant carers (Figure 6.6). This was followed closely by poor proficiency in the English language (65%) and the requirement for extra job training (63%). Acceptability of migrant carer qualifications, or the lack thereof, featured as a challenge for 44% of employers, as did government regulations. An equal proportion of respondents (37%) found that lack of assertiveness and lack of decision making skills among migrant care workers were an issue. Under a third of employers (30%) thought that migrant carers were not well accepted by older people, while only a quarter said that higher turnover was a problem when employing migrant care workers.

The overall pattern of findings was generally maintained across all residential care organisations. However, private home care organisations were less likely to report poor English language proficiency, poor knowledge of culture and the need for extra job training as challenges than the other organisations. Private home care



employers were also less likely to report lack of assertiveness and lack of decision making skills as issues. By contrast, private home care organisations were more likely to report that migrant carers were not well accepted by older people. Qualifications not readily accepted and difficulty with regulations were more likely to be reported as challenges by private nursing homes than any other organisation. Differences across organisation size did not emerge strongly.



Source: Employer survey

Care Preferences

In Chapter 3, preferences for care as established in the literature were outlined at a general level. In this section we look at the preferences for care of the older people who took part in this research.

Preferences for care are intrinsically linked to concerns about who should provide care and where that care should be provided. While the former is of most concern in this study, both sets of preferences are closely related, with care settings influencing the desire for certain personal and professional characteristics of a care giver. Drawing on the findings of the focus group discussions, this section explores some of the preferences of current care users (nursing home residents) and prospective care users (community residents). Understandably, there was a distinction between those participants who lived in a nursing home and those who resided in the community with respect to these preferences.

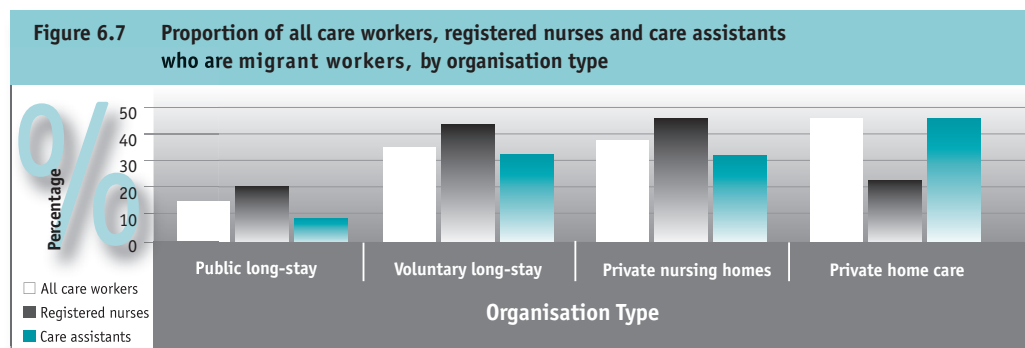
The nursing home participants were very appreciative of the care they received in their facility. *“I think it’s wonderful to have here, I would be on my own only for here...we have no complaints”* While they recognised the comfort in being cared for by one’s own family, participants stated that the *“...most important thing is that you are just cared for.”* Similarly, *“If you can’t be looked after at home, aren’t you very happy to be looked after [at all].”* Individuals spoke about the qualities of caring, kindness and compassion as being more important than any technical skill set or the nationality of the carer. *“I know that the skills are very important too, but sure if you haven’t compassion for the person you’re looking after, what good is it all... do ya know, if your not kind and that.”* One participant stated *“That’s all you want, that they [carers] are kind and caring and they won’t beat you up [laughing].”* To have an understanding of an *“older person’s situation”* was also held as a valuable attribute for a carer. This empathy was thought to facilitate a stronger bond between the people receiving and delivering care.

The community residents wanted to be cared for in their own homes and preferably by their spouses or families. *“We would like to stay at home, thank you... it would be the first choice for me.”* The perceived long-stay care environment was heavily criticised with concerns expressed about over-medication, lack of stimulation and abuse. *“All those poor old people do in nursing homes is sit in a chair, that’s all they do ... because you have very few nurses on duty in a nursing home... and a couple of care workers and they need so much more, I mean I get very angry over the way we treat our older people... they have no stimulation in the majority of nursing homes.”* For some participants, the experiences of relatives and friends supported these perceptions and underlined their strong desire not to have to live out their lives in such facilities, whether cared for by indigenous or foreign care workers. *“To have to go into a nursing home... at half six they come around and give you your pills and your breakfast, you don’t want to be up at half six...”* [Another participant interjects] *“And then at half six in the evening they shove you back into bed”*. However, it was accepted that because of their families’ work commitments, the participants would more than likely require some form of paid care in the future. The focus, therefore, would be on finding someone who is caring to look after them in the future. *“A caring person... to be caring to start with.”* This preference was expressed independent of nationality.

Supply

Migrant Care Workers in the Older Adult Health and Social Care Sector

Just under a third (31.6%) of all care workers in the organisations surveyed are foreign nationals. This is in contrast to the general health and social care sector and the overall Irish labour force where 16% and 15% of workers respectively are from another country (CSO, 2006²; CSO, 2009). With reference to Figure 6.7, the largest proportion of migrant care workers are in the home care sector with 46% working in private home care organisations. Thirty seven per cent of care workers in private nursing homes, which constitute the primary source of long-stay care beds in Ireland, are from other countries. The lowest proportion of migrant care workers are in public long-stay care facilities (14%). In home care organisations, there are significantly less migrant registered nurses than care assistants, reflecting the focus on personal rather than medical care. However, for all other organisation types there is a larger proportion of migrant registered nurses (39%) than migrant care assistants (27%). This would suggest that the labour migration into the older adult care sector is primarily of a high-skill nature, reflecting the difficulty that employers experience in hiring Irish registered nurses.



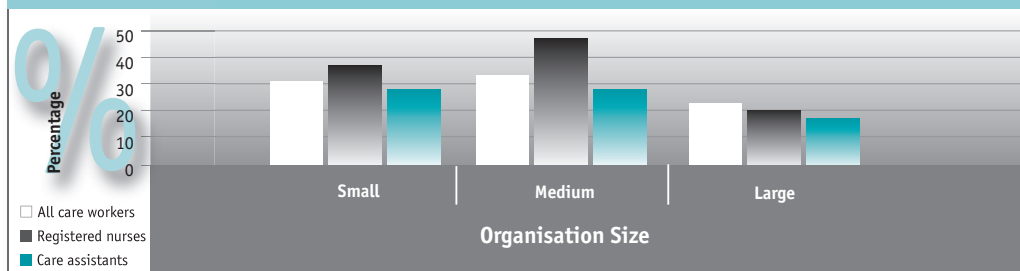
Source: Employer survey

NOTE: Public long-stay = HSE extended care units, HSE welfare home, HSE district hospital and HSE community hospital; Voluntary long-stay = voluntary geriatric hospital and voluntary geriatric home; all other categories as listed.



Medium sized organisations employ the highest proportion of migrant care workers. Small organisations employ the second highest proportion; while large organisations employ the lowest proportion (see Figure 6.8). This pattern is maintained for registered nurses, but alters for care assistants, with small organisations employing a marginally higher proportion of care assistants than medium organisations.

Figure 6.8 Proportion of all care workers, registered nurses and care assistants who are migrant workers, by organisation size

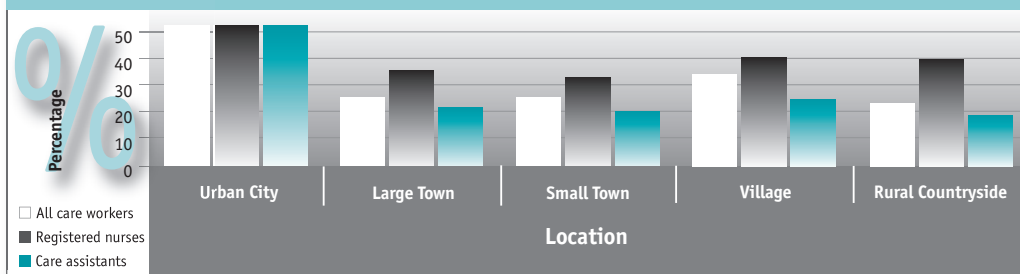


Source: Employer survey

NOTE: Small = organisations caring for 50 or less older people; Medium = organisations caring for 100 or less older people; Large = organisations caring for more than a 100 people.

As evident from Figures 6.9 and 6.10, migrant care workers are working across all regions and locations, reflecting the general representation of foreign nationals throughout Ireland, which was described in Chapter 4. Nonetheless, the geographic distribution of migrant care workers is concentrated in large urban centres, with foreign nationals comprising more than half of all care workers (54%) in city locations. As may be expected, organisations in the rural countryside have the lowest proportion of migrant care workers (23%). Interestingly, however, employers in village locations employ a higher percentage (33%) of migrant care workers, than both small (25%) and large town settlements (25%). In addition, organisations in the rural countryside employ a higher proportion of registered nurses (39%) than those in large (35%) and small (32%) towns.

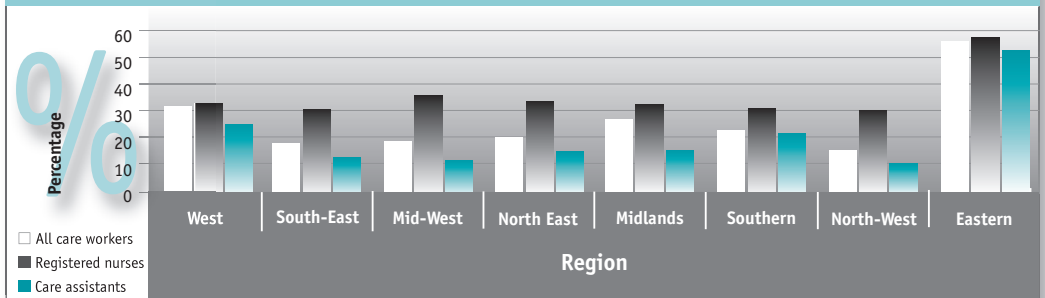
Figure 6.9 Proportion of all care workers, registered nurses and care assistants who are migrant workers, by location of organisation



Source: Employer survey

While the North-West region has the lowest proportion of migrant care workers, the highest proportion of migrant carers are in the Eastern region of the country.

Figure 6.10 Proportion of all care workers, registered nurses and care assistants who are migrant workers, by region of organisation

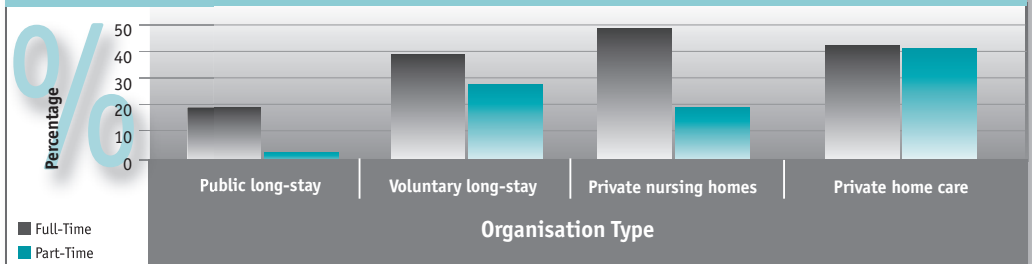


Source: Employer survey

The Western region has the second highest proportion of foreign carers, continuing the pattern of strong migrant care worker representation in both urban and rural areas. When these proportions are broken down by occupation category, the proportion of registered nurses is higher in the Mid-West and North-East than in the Western region. The geographic distribution of migrant carers can be contrasted with employers' difficulty in hiring Irish carers presented in the previous section. Together these findings suggest that the distribution of migrant carers, and thus the demand, is strongly linked to problems in recruiting and retaining Irish care workers. This is particularly evident for city, rural countryside and village locations. However, there does not appear to be a linear relationship between settlement size, or the urbanisation/rurality of geographic regions, and the demand for migrant carers.

Across all organisation types, there is a greater proportion of migrant full-time carers than there is migrant part-time carers, marking a predominance of migrant full-time carers in the sector. With reference to Figure 6.11, only private home care organisations have a similar proportion of migrant full-time and part-time carers.

Figure 6.11 Proportion of full-time and part-time care workers who are migrant workers, by organisation type

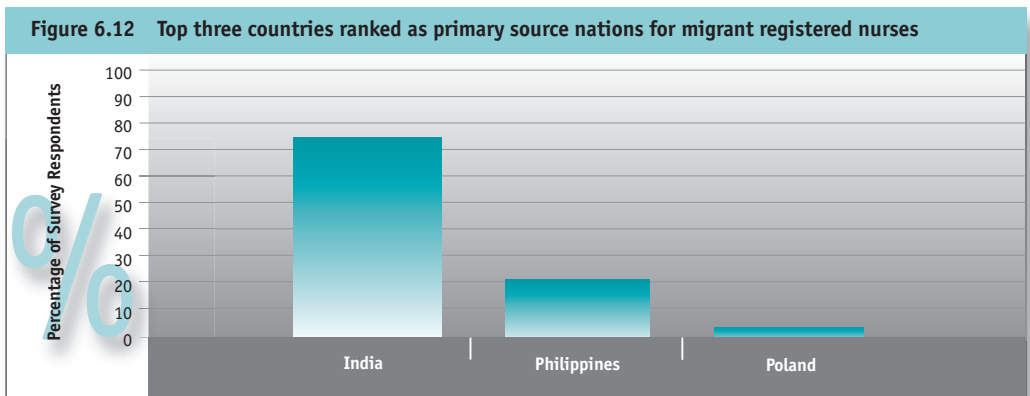


Source: Employer survey

NOTE: Public long-stay = HSE extended care units, HSE welfare home, HSE district hospital and HSE community hospital; Voluntary long-stay = voluntary geriatric hospital and voluntary geriatric home; all other categories as listed.

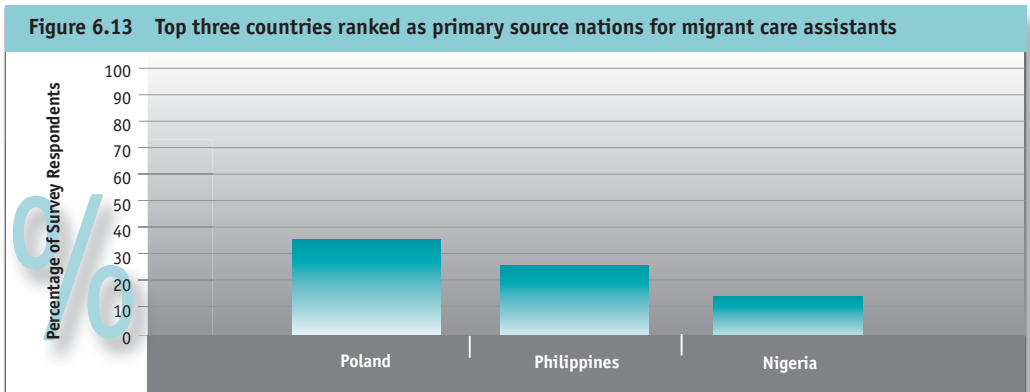


Figure 6.12 illustrates that India was ranked by almost three-quarters of employers (74%) as the primary source country for registered nurses. The Philippines was the second strongest supplier of nurses with a fifth (20%) of respondents ranking it as the primary source nation. These figures are representative of the Irish nurses' register and indicate the ascendancy of India over the Philippines as the primary source of registered nurses in recent years (5,466 versus 4,091 on the active register- March 2008). Poland was the third strongest supplier of registered nurses (294 on the active register- March 2008), but with just 3% of employers ranking it as the primary source, it does not appear to be a significant contributor to the nurse workforce in the sector. Employers did list eight other countries as sources of registered nurses, but these nations did not feature strongly in response proportions.



Source: Employer survey

Referring to Figure 6.13, the primary source countries for migrant care assistants are not dominated by a single nation to the same extent as for registered nurses.



Source: Employer survey

Poland was the most important supplier of migrant care assistants, with 37% of employers ranking the nation as the primary source country. A quarter of respondents listed the Philippines as the primary source country, while 11% of employers ranked Nigeria as their strongest supplier of care assistants. Employers listed a number of other nations as source countries for migrant care assistants. Aside from India (ranked by 9% of employers as the primary source of care assistants), these countries did not feature strongly in response proportions.

Source Country Data: A Case-Study Analysis

In order to inform the international comparative aspect of this research study, case-study reviews were completed for a number of source countries that were common to the participating countries (i.e. Ireland, UK, US and Canada). While addressing issues surrounding source nations is outside the scope of this research, it is important to at least capture the perspectives of these countries to achieve a holistic understanding of supply-side behaviour. Two of the case-studies are relevant to the Irish context; the first focusing on the Philippines and the second on Poland. Although not the primary source of either registered nurses or care assistants in Ireland, the Philippines is perhaps the most significant supplier of both occupations. Our connection with the Philippines also marks the longest running immigration relationship for care workers in the state. Poland is the primary source of migrant care assistants and appears to be a growing supplier of registered nurses. The following sections presents a summary of these case-studies, describing the context of health and social care worker immigration in the Philippines and Poland and contrasts the systems and scale of migration existing in both countries.

*The Philippines*¹³

The widespread restructuring and privatization of health care systems, the growing ageing population in the Western world, and the shortages of local health care workers (nurses in particular) resulted in an unprecedented mass recruitment of healthcare workers from the developing to the developed world. This pattern is no more evident than in the Philippines, which by 2004 had become the number one international exporter of nurses, supplying all four country sites participating in this research (Ireland, US, UK and Canada). Nurses occupy positions in hospitals, and nursing homes across the US, while streams of professional ‘caregivers’ leave the country to provide bedside assistance to households all over Canada. In addition, due in large part to aggressive recruiting practices by statutory and private recruitment agencies, unprecedented numbers of nurses and care workers have migrated to the UK and Ireland. Philippine workers entering these four countries have also started doing so from transit countries such as Singapore and Hong Kong. As of March 2008, there were 4,091 Filipino nurses on the active nurse register in Ireland.

The Philippines is not new to large-scale labour export and the current exodus of Philippine care workers is but another link in a long chain of labour migration that dates back over a 100 years. The country’s colonial past is a significant factor, as it helped lay the foundation for the mass migration occurring a century later. In recent times, the implementation of Martial Law by former President Ferdinand Marcos in 1972 led to a rapid corrosion of Philippine economic institutions, triggering substantial outward labour migration in the 1970s. While initially this immigration was dominated by male workers, a growth in the need for healthcare, administrative and domestic workers meant the increased ‘feminisation of migrant labour’. Since 1992 the number of female labourers leaving the Philippines has outnumbered males.

Transnational ties between labour migrants and family members back home were tangibly maintained through remittances, which, collectively, continue to form a substantial pillar of the Philippine economy. Amounting to an estimated US\$10 Billion a year, remittances helped cushion the economy from the Asian financial crisis of 1997, and the various political crises that plagued the Philippines in the early 21st century. Economic dependence on remittances, and ultimately, on migrant labour, has become more and more institutionalised. Arguably, human labour has become the number one export of the Philippines.

■ ¹³ Extracted and summarised from; *Gordolan, Lourdes (2008). Source Country Report: The Philippines. The Role of Migrant Health and Social Care Workers in Ageing Societies-August 2008.*

The International Organization for Migration has stated that the Philippines is at a 'world standard' in the management of migration. The Philippines was one of the first nations to establish a state institution to deal with labour exports: the Philippine Overseas Employment Agency (POEA) facilitates and oversees the movement of millions of Philippine labourers to workplaces around the globe. In particular, the POEA sets minimum standards and regulations for private recruitment agencies, mediates between foreign employers and Philippine workers, protects 'Overseas Filipino Workers' or 'OFWs', and conducts research on emerging labour markets around the globe. The POEA is ideally the first point of entry for foreign states or employers seeking contractual labour from the Philippines of any sort. Filipino citizens who wish to work abroad are also required by law to register with the POEA. While the POEA is the only recognised government institution devoted to Philippine labour migration, many other government institutions play significant roles in the deployment of health care workers.

Tertiary education, in general, has restructured itself over the last 10 years to cater to global care and nursing demand. There has been an unprecedented 'mushrooming of nursing schools,' with 107 new institutions opening from June 2003 to April 2004, representing a 41% increase. The rapid proliferation of nursing colleges makes it increasingly difficult to standardise nursing quality among graduates, particularly as many are privately run and are motivated by profit. A university education is still considered a weighty financial investment in the Philippines. Families who pool together enough resources to send a son or daughter to nursing school try to ensure that their degrees will literally pay off. Nursing and care work has become synonymous with employment abroad and career stability.

Private training institutes have been quick to cash in on the number of students hoping to invest in a nursing or carer-related degree. In early 2003, vocational training institutes, formerly specializing in Information Technology (IT), began to switch their focus to nursing and other health-related fields. Such a rapid, unregulated growth of nursing schools eventually compromised overall quality in nurse training, with passing rates for the National Nursing Board Exam declining consistently since 1994. A large number of vocational schools and training institutes offer similar training in what is termed 'care giving.' Training schools are predominantly privately-run, and together with private universities produce skills in response to the global labour market. Although government regulated, reproduction of nursing and caring skills within the private sector is uneven at best, and unregulated at worst. Due to loopholes in the POEA structure, private employers and even governments often deal directly with training institutes to avoid the lengthy bureaucratic process. Philippine government institutions acknowledge that these arrangements are in place and in some cases draft memorandums of understanding to manage this process.

A lucrative private recruitment industry has emerged to cater for foreign employers and Filipino labourers. The POEA lists nearly 3,400 approved recruitment agencies in its records. There are little regulations governing these agencies, with few guidelines on job standards, ethical recruitment, or skills matching. The sector is heavily business-oriented, and deals mostly with revenue requirements. Previous research has observed that recruitment arrangements from the Philippines to the UK and Canada tend to involve a higher degree of state involvement, while recruitment to the US and Ireland (to a lesser extent) tend to rely less on state channels and more on private recruitment agency and direct employer-employee arrangements.

Having institutionalised the labour migration process, the Philippines is likely to remain one of the top labour suppliers in the health and social care sector.

Poland¹⁴

Polish labour migrants use many different strategies to secure employment abroad. However, in contrast to the institutionalised migration process in the Philippines, most of these strategies are not supported by formal state led infrastructures. In general, and understandably, the migration information available in Poland concentrates predominantly on nations that are in close proximity to the country. These nations typically have a more established history of migration with Poland, whereas Ireland has only recently developed as a host nation – almost 90% of Polish immigrants have arrived in Ireland since 2004.

Several formal recruitment schemes for health and social care workers have been established over the years, but overall did not appear to be too successful. These schemes primarily commenced with the establishment of the EURES job mobility portal in 1993. EURES is a co-operation network between the European Commission and the Public Employment Services of the EEA Member States and other partner organisations. The joint resources of the EURES member and partner organisations provide assistance for workers to cross borders for employment, providing information, advice and recruitment/job-matching services to both workers and employers. EURES has a network of more than 700 EURES advisers that are in daily contact with jobseekers and employers across Europe. The director of the Public Employment Services in Poznań who also acts as a EURES Advisor indicated that when EURES was first established in 1993, recruiters interested in nurses and social care workers would contact him and even make visits to Poznań to recruit workers. However, these visits and offers are less frequent in recent years.

Fieldwork in Poznań for this study indicates that most Polish carers use informal networks and ‘word of mouth’ strategies to obtain employment in the health and social care sectors abroad. Discussions with prospective and returned migrants in Poland revealed that nurses – both those who want to work as nurses and those who are willing to work as care workers – try to arrange employment before leaving the country. Conversely, young people, who end up working as social care workers or care assistants, usually leave Poland without a job offer and with a very vague idea of what they want to do in destination countries. Many young people, particularly, students go to the UK or Ireland with the hope to continue their studies or to pursue employment in their field of studies. They do, however, understand that if these plans do not work out, they can always fall back on working as an au pair or a live-in care giver. According to the EURES Advisor in Poznań, 90% of those wanting to work abroad do not know anything about labour laws in the country they want to work in.

Short-term circular migration to neighbouring countries is particularly evident amongst Polish carers. The majority of nurses interviewed from Poznań worked mainly in Germany and Italy on short term contracts of three to six months or even shorter. This form of migration is related to work and vacation schedules that allow Polish nurses to take several weeks or a few months off to work abroad. Some nurses work as social care workers in private homes on a rotational basis. Care assistants without a formal health care background follow a similar pattern. A number of care workers care for elderly patients in their homes in Berlin for three to four days a week and return to Poznań for weekends. This strategy is less frequent among people seeking employment in the UK and in Ireland, but not unusual. In Poland, most nurses work two to three jobs to make ends meet and virtually have no time for their children and families. As a consequence, and in contrast to the evidence of short-term circular migration, a representative of the International Organisation for Migration felt that most nurses who found good jobs abroad did not return.

■ ¹⁴ Extracted and summarised from; *Goździak, Elzbieta (2008). Source Country Report: Poland. The Role of Migrant Health and Social Care Workers in Ageing Societies-August 2008*

In the case of Germany, the recruitment process is primarily managed by health care agencies looking for health and social care personnel. In Italy, Polish social care workers rely more on formal and informal networks established by the Catholic Church. For Ireland and the UK, there appeared to be few if any formal arrangements for state sponsored nurse and care assistant recruitment. Yet, at the time of the 2006 Census there were 63,276 Polish people living in Ireland, which for many is considered to be a gross underestimation of the actual figure. While there are only 294 Polish nurses on the Irish active nurse register (as of March 2008), this number is likely to rise in line with the proportion of Polish care assistants—ensuring that Poland will remain an important source country for health and social care workers for older adult care.

Entering Ireland and Older Adult Care

In exploring factors that influence the supply of migrant carers, it is helpful to understand why migrants decide to work in Ireland and the older adult health and social care sector and how they obtain employment. An understanding of migrant carer motives will provide insight into potential future intentions and the long-term sustainability of this workforce supply. Focusing on the principle channels and pathways to employment is important to identify formal and informal mechanisms that ultimately facilitate the supply of foreign national carers. This section of the report investigates these factors.

*Reasons for Migration and Channels into Ireland*¹⁵

Most of the participants (31) interviewed chose to move to Ireland for economic reasons. They believed they would have more opportunities and enjoy an improved standard of living in Ireland. For instance *“I looking [for] a much better job and good salary, yeah...”* A number of these participants also saw it as an opportunity to broaden their horizons as an Indian nurse describes, *“Actually from childhood onwards, I have an ambition to fly to any... European country... I think here I will get good opportunities to mingle with the different people that came from different countries, like Poland, or USA, something like that. We can mingle and we can share our knowledge, something like that. Then I also think I’ll also get good job opportunities here. Then after that, I’ll also get a good salary I think. In India, we don’t get this much salary...”* Four people left for family reunification reasons, primarily, to follow their partner who was already working in Ireland.

The remaining five participants emigrated for human rights reasons. Therefore, their move was not voluntary and instead was motivated by the need for safety. *“I didn’t really choose...I’m a refugee, if you’re a refugee, you don’t have a choice of where you’re going. If things go bad in your country,...you get help wherever you can get it...but I’d say I don’t regret coming in here so far, because it’s a lovely country to live in. So although I didn’t choose it, it was matter of do or die, but sure...I really appreciate being here, it’s a lovely country to live.”* Some of these participants spoke about fleeing from religious persecution or war and conveyed a strong sense of devastation. *“The main purpose of my leaving my country is we had a crisis... between Muslim and Christian ... Because of the crisis problem between the Muslim and the Christian, though it is still on now but not like before... It was so serious that some member of my family, I lost them due to the fight, so me and my husband decided that we have to leave.”*

The work permit was the chief immigration channel for interview participants (17). The fast track channels for nurse recruitment were the next most popular and included the old work visa system (6) and the

■ ¹⁵ Dr. Adeline Cooney, School of Nursing and Midwifery at NUIG, contributed to the writing of this section.

replacement green card system (3). A similar proportion of participants entered under EU citizenship (4) and the channels for family reunification (3).

For most participants there was an initial stage of 'uprooting'. Typically, the journey began by gathering information about the move, for example, what Ireland was like, where it was, what was involved in moving and was it easy to get work. The sources of information varied and included the Internet, friends or relatives who already worked in Ireland or recruitment agencies. *"My cousin [is] in Cork, so that's why [we moved here]. We communicated by ... Skype, and he pushed us 'come, come to visit me and decide."* Likewise, *"[Most people don't] know anything about [Ireland] ... In 2001 when my friend came, she was the first person who came in... so once they came, then they will spread the message you know. Now it's very popular now! Everybody started coming like, because earning is more, we can earn more here, so that is the good way to come over here."*

People coming as asylum seekers (7) did not have the luxury of preparing themselves in advance. Those who were smuggled into the country did not even know to which country they were being taken. Consequently, their initial experiences of Ireland were traumatic and frightening. *"In my case, it was like partly religious, partly family problem ... so eventually we decided to leave... When I came to Ireland, I was like...I don't know how to describe it now! [Laughter] I was just in the middle of nowhere! I don't know anybody, I don't know anything, I was just left in ... you know the bus place in Ireland, near Dublin ... the person that brought me left me there. So it was like 'You are here now, you can sort yourself out' ... I sat down and I was crying and crying ... I didn't know anyone, ... and the people I saw are just Irish people really ... but ... I felt this homely environment ... because people I saw, even though they are not my type like, sorry to use that word now, they are not coloured people, they still felt concerned like... 'What is your problem?', 'Do you have any problem?', 'Are you in labour or something?' because I was pregnant. But I said 'No, I still have a long way to go'. They said 'Well ok, how can we help? Do you need to call somebody?' They offered me their mobile phone so I could call anybody, but who am I calling? I don't know anybody... A man give me direction 'Ok, you go to the immigration, and tell them your problem and maybe they can sort you out, or tell you where to go, or tell you what to do if you are stranded'. So in tears, and cold, I have no jacket ... if I know that I'm coming to a cold place, at least I would have had a jacket ... [the man] took me to this place to tell them my story. So I went there and I told them my story 'Ok, what is your name?' blah, blah, blah. They gave me a form I fill, and that is how my journey started in Ireland."*

Some participants had deep regret about leaving their home country. Their initial experience was sometimes very difficult and lonely especially if they were separated from their spouse or family. *"I have two children, my husband I miss a lot, and [this is] the first time I left them. Yeah, I feel such loneliness here. When I go home, I have to spend in one room alone, so I feel so loneliness here... Anyway, I think within two months or three months, I have to bring them, because I can't...I can't..."* Though, the initial homesickness was somewhat tempered by the opportunities that living in Ireland afforded people. *"You can do well here, you can settle here, you can achieve great... you can you know move on with your life here ... [in Africa] there was like no reason to stay anymore."*

Reasons for Entering Older Adult Care Sector and Pathways to Employment

There were primarily three broad themes underlying why participants decided to care for older people. The first of these concerned personal preference. *"I know loads of my friends said 'How can you do that?' Like you can go around ...be in some insurance companies, or whatever, or clean nice job. But I said 'I don't want to do that!'...I like my job, I really enjoy it!"* Although, the factors that influenced this choice did differ across the participants. For some, older adult care was about gaining new experiences, both in terms of the working environment and trying something different. Others decided to enter the sector because they had previous experience of caring for



older people. The experience related to professional qualifications and knowledge of formal work settings, or to past associations with older relatives and their role as an informal caregiver. *“I know that job before in Ukraine, and ...because I’m living with my grandparents all my life. My family always have friends - only old people... And always I’m seeing in my house only old people! ... Absolutely natural, yes [to be a carer].”*

The second theme focused on older adult care as a ‘stepping stone’ or a gateway to a more valued position. This was particularly true for registered nurses, who sought experience in the health and social care system as a means of obtaining a job in an acute setting. *“It is the only work available for the first time nurses... because most of the time hospitals will ask for care and experience here before they hire you. So basically... nurses need experience in nursing homes before you can go to big institutions like hospital.”* Another nurse commented on how older adult care served as an introduction to the Irish system of care. *“Because it was the handiest for me at the start, from the start - rather than just going to hospital. It’s better I said to just start at the beginning.”* This is supported by the comment of one employer to an open survey question. *“Migrant worker’s use nursing homes as a stepping stone to better opportunities. They may be highly educated and skilled in other fields.”*

Thirdly, and perhaps the strongest underlying theme, concerned the simple need to acquire work and the opportunity for employment that older adult care provided. Participants described caring for older people as the first job that they could find, or in the case of foreign recruitment, the first job that they were offered. This is evident in the following statement of one registered nurse from India. *“It was just because it was the job that was available... so it was according to the recruitment agency, they got a placement over here, and I just had to start, and take it.”* Other interviewees spoke about the additional influence of friends and family who were already working in the sector. *“I was thinking... what I am going to do? So a friend of mine... did the training for care for the older people. She did it first, so she was the one that told me that I should go for the care for the older people.”* Spousal influence was particularly evident for male carers, whose previous qualifications were not recognised and who came to Ireland as dependents. One participant, who had a previous degree in computer programming, outlined this path into older adult care. *“My wife [was] working here for six years as a carer ...before I came here, my wife told me to take a nursing course, because it is much needed here, it’s much in demand here, so that I can work here.”*

Another individual commented on the role of FÁS, the national training and employment agency, as a means of entering the older adult care sector. *“You go to FÁS, you tell them who you are, where you’re from, and tell them this is what you have... sometimes they do training, sometimes they employ you while you are training, and you get paid... And they gave me... a series of things that they do, you know, if there’s anyone that I can be able to fit in, so that is how I got involved in the care for the elderly really.”* Several participants had completed the ‘Care for the Elderly’ training with FÁS.

While for some people these themes continued to underlie their current reasons for caring for older people, for others the themes changed over time. Interviewees spoke about becoming comfortable working in the sector and appeared to establish an attachment to caring for older people as a profession. *“Although it’s not really planned before I came to Ireland to mind the elderly for good. You know for a long time I think I only work for a year and then go to a hospital but then I realised, oh god, I love this type of job. So it’s really this kind of job I love to do, to work.”* Interestingly, almost three quarters of those interviewed intended to be still working in the older adult care sector in five years time.

Informal Networks

Informal networks featured strongly in the recruitment process, with many individuals sourcing employment through friends and family already working in Ireland. *“My friend told me ‘...I have a job like carer, maybe you want? And I say ‘oh yes I want!’...And she said ‘ok, I’m go speak with my boss’ and really she is bringing me application form, and Garda clearance form, everything, and I’m apply, and get that job.”* For a male Latvian care assistant the experience was similar sourcing employment through his mother’s friends, *“Like some of her [his mother] friends were living in Ireland already and they said we have some vacancies so... It’s like I came in the evening, we are showed the nursing home... then we were showed the house and next morning we start to work. We had everything like the working permits, we have the bank accounts, PPS numbers. Everything was taken care of.”* Religious networks also featured as a means of identifying employment, particularly in the Philippines. *“I rung my friend, an Irish priest, because I studied in an Irish priests’ Columbian school, a missionary, so I asked him. And he rang his home here in [Ireland]... So when he told me...ok they’re hiring, that’s fine.”*

Informal networks were also a part of employers’ strategies for hiring foreign national carers. While routine local and regional advertising was used to employ migrant care workers, informal networks were said to feature strongly with employees referring friends and family for care positions. *“Word of mouth seems to get around. We’ll say we have a migrant worker here, he’d tell someone back home...so we’re getting CVs and applications all the time from abroad.”* Although this strategy was primarily mentioned in terms of care assistant recruitment, informal networks were also operational in the recruitment of registered nurses within and outside the EEA. Employers spoke about how utilising such networks can provide a security with respect to the quality of the employee that was being hired. Two fifths of survey respondents stated that better personal contacts for hiring other foreign national carers was one of the advantages of employing migrant workers – see Figure 6.5. Voluntary long-stay facilities (64%) were more likely to view these personal networks as an advantage, followed by public long-stay employers (58%), private nursing homes (56%) and finally private home care organisations.

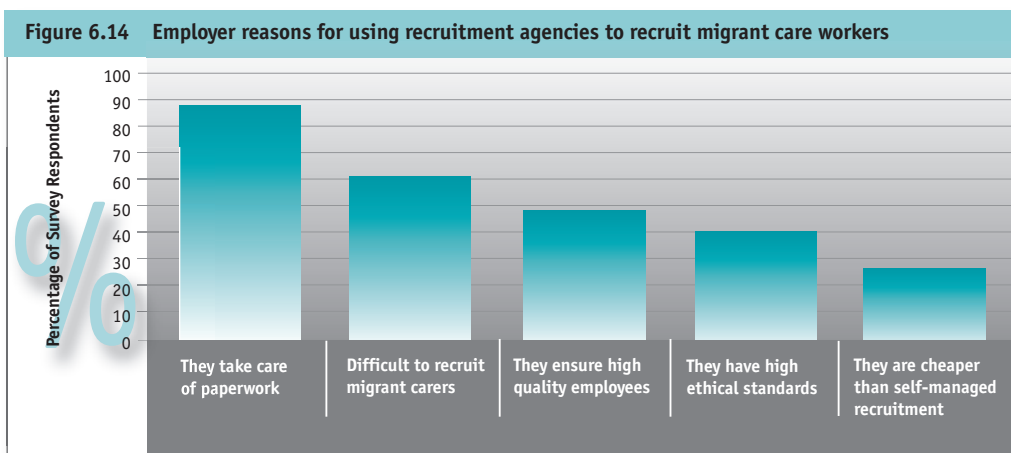
Recruitment Agencies and Employment Agencies

Other participants found employment through recruitment agencies. It was common for people to be hired by an employer, or a group of employers, working with a local source country recruitment agency. *“I read the advertisement and went up to the recruitment agency in the Philippines... and one of the interviewers was the owner.”* For those residing outside the EEA, this appeared to be the primary channel of recruitment. If hired as a registered nurse, interviewees whose qualifications were not readily recognised (e.g. those from the Philippines) underwent an adaptation course when they arrived in Ireland, as a part of this process. In a small number of cases, participants described how recruitment agencies effectively double charged, with both the Irish employer and the care worker incurring a fee. *“The [recruitment] agency is really making a good profit from those people work abroad, like I didn’t even know since I came here, my employer first she said ‘they paid everything for me to come over’ but I told them no I paid something because the agency wants us to pay like the processing fee...”*

Direct recruitment was also evident, as one Filipino nurse describes *“It was a director hiring here. She was the owner of the nursing home... and they want to hire Filipino nurses or care assistants. So they went directly to the Philippines to hire nurses and care assistants. And they did the interviewing on their own and the screening on their own ...”* In this case expenses for bringing the person to Ireland were offset against the individual’s salary. *“So they pay in advance all our tickets, all our accommodations and then it was deducted from our weekly salary as soon as we get started here.”*



In the case of employers, just over 42% of those respondents who employed migrant care workers used recruitment agencies to assist in the employment process. As shown in Figure 6.14, the primary reason given for using these agencies is because they take care of paperwork (89%). The difficulty in recruiting migrant care workers was the second strongest reason (62%). Just under half (49%) of respondents using recruitment agencies said they ensured high quality workers, whereas 40% stated that recruitment agencies have high ethical standards. Only 26% of employers thought that recruitment agencies were cheaper than self-managed recruitment.

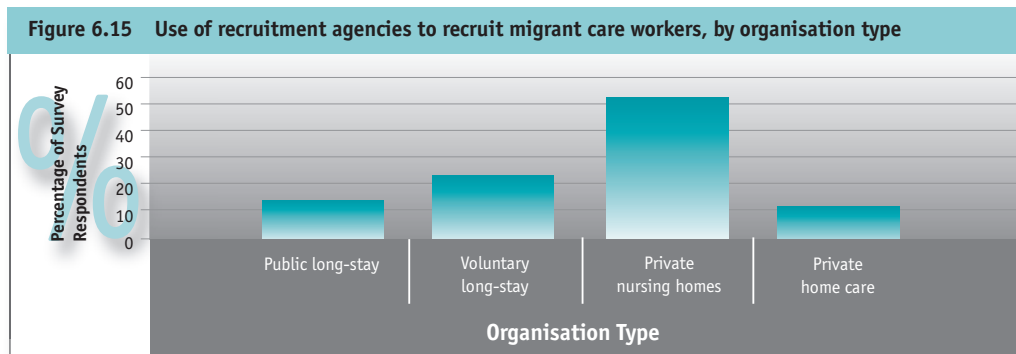


Source: Employer survey

Comments to an open question on recruitment agencies reflected these responses, with a large number of employers mentioning the advantages of using recruitment agencies to handle paperwork and regulations. *“Helpful, informed on changing recruitment laws. Anxious to keep paperwork efficient.”* Other employers noted the expense involved in using such agencies, but also recognised the benefits. *“Expensive but take care of ever changing bureaucratic paperwork.”* The quality of workers sourced through recruitment agencies varied across employers- some described very good experiences, while others described very bad experiences. *“We have had some excellent, extremely competent workers employed via recruitment agencies. We have also experienced completely inappropriate placements causing extreme difficulty in the work place.”*

Generally these comments were supported by the participants in the employer telephone interviews. A number of respondents described issues and concerns with the agencies. *“In one case of a staff nurse... I was led to believe that her English and everything was perfect... but I found when she came, her English was very poor.”* The most extreme of these focused on the experiences of one employer, who had found that recruited registered nurses had been charged significant fees before coming to Ireland. *“I only use [a] recruitment agency for Indian nurses and they are totally unethical. They charge all the nurses €6000 - €7000 in India before they come here.”* This supports the experience of one migrant carer as outlined above. Another participant who had problems with the work of a newly recruited nurse discovered that the person was previously reported for misconduct in the UK. Finally, employers felt that they and their employees did not receive any support once the care worker started work. *“Once the employee is in the country there appears to be no support for them or us.”*

Figure 6.15 shows that private nursing homes were more likely to use recruitment agencies than any other organisation type (52%). Voluntary long-stay facilities were the next most likely to use recruitment agencies (23%), followed by public long-stay facilities (14%). Only 11% of private home care organisations reported using recruitment agencies. This pattern is also reflected in the size of the organisation. Small organisations are more likely to use recruitment agencies (41%) than medium organisations (36%) or large organisations (21%). These findings reflect the fact that the recruitment for larger public organisations was centrally managed through human resource departments.



Source: Employer survey

NOTE: Public long-stay = HSE extended care units, HSE welfare home, HSE district hospital and HSE community hospital; Voluntary long-stay = voluntary geriatric hospital and voluntary geriatric home; all other categories as listed.

The use of recruitment agencies appeared to be skill driven, with the majority of survey respondents (69%) stating that recruitment agencies were better for hiring migrant nurses than migrant care assistants. There appeared to be several reasons for this strategy. Recruitment agencies were primarily only used for recruiting staff outside the EEA, particularly from India and the Philippines. Thus, employers concentrated within the EEA countries and the existing pool of migrant workers in Ireland for care assistant positions. In any case, approval was said to be rarely given for a work permit for a migrant care assistant outside the EEA.

Eleven per cent of employers used employment agencies for hiring migrant care workers. Primarily only larger long-stay facilities, such as those in the public and voluntary sector employed staff through employment agencies. In the case of the public sector this strategy appeared to be directly related to the recruitment restrictions currently in operation in the Health Service Executive. Again reduced paperwork was cited as the primary reason for using these agencies (45%), followed by the advantage of being able to let contract workers go more easily (41%).

Migrant Workers as Carers



*“Sometimes you all for them,
maybe family could come in once a week,
and you be carer, you be friend, you be family, you be assistant,
you be everything for them...”*

Latvian care assistant speaking about caring for older people

This chapter focuses on being a migrant carer in the older adult health and social care sector in Ireland and the various factors that impact on the experiences of foreign nationals caring for older people. The chapter concentrates primarily on data from the migrant care worker interviews, but is augmented, where appropriate, with information gathered from the employer survey and employer interviews. The influence of duties and responsibilities, salary and conditions, workplace relationships and immigration and employment regulations are explored in the following sections.

Caring for Older People: Duties, Responsibilities and Challenges

Even though there are certain distinctions across work settings, skill level, and older adult dependency level, the everyday duties of migrant care workers are primarily concerned with the delivery of personal and social care. As would be expected, the routines of the care workers are orientated around the basic activities of daily living, whether in terms of assisting in these tasks directly, or managing other care staff during their completion. Nevertheless, participants recognised that the social aspects of care are important to the well-being of older people, *“My duty...it depends, but the main job there is getting them up, dressing them, giving them a shower, and feeding them... But all that and just to make sure that you keep them company so that they will not feel like they are being isolated. We keep them company and always make sure that they are busy doing something, that is it.”* For live-in carers, the typical day involves a greater range of duties, including meal preparation and other household tasks.

A small number of interviewees felt that the duties they have to perform are sometimes outside the scope of their role. In long-stay care settings, such issues typically surround the distinction between the tasks of a nurse and a care assistant. One care assistant commented that *“If the nurses ask [us] to do something, for example, to change colostomy bags, it’s the nurse’s job, but...if they do this once, they will keep going to do this... Some kinds of jobs, we feel is not our jobs. It should be the nurse, she should be doing this, not the carers.”* Conversely, in home care the boundary between personal and domestic assistance appears to be sometimes blurred as a public home carer describes, *“I was sent to a man with cancer, I was sent only there for personal care, yeah...so after doing the personal care, the sister wants me to Hoover, and I don’t know how to Hoover you know! So I give it up, because I don’t know, so I’m afraid I might explode or something! Because I don’t know the job you know.”*

However, for the most part, participants did not feel that they were being asked to perform tasks outside their area of responsibility. A number of participants did note that there is sometimes a need to be flexible with respect to duties of care. For instance, a nurse working in a nursing home stated, *“I said to myself ‘you’re in the nursing home now, you have to help also’, because sometimes it cannot be avoided...It’s better, it’s just teamwork.”* A similar sentiment was expressed by a male care assistant, *“You know, if I am looking after an old man or woman, I should take full responsibility anyway. I cannot say it is not my responsibility...I should fully take care of him.”*

Some respondents in the study did highlight the routine-driven environments of long-stay care settings. One care assistant commented that, *“The nursing home...they’re going according to timetable - one o’clock we have to feed them, change their pads, you know...there’s a timetable every day...They don’t have time of saying... ‘oh today I’m not well, I don’t want to go to mass’ or ‘today I don’t want to eat whatever is cooked, I want something different’. They don’t have any choices.”* Some interviewees also noted the disparity in staffing ratios between private and public institutions. As a consequence it was said that the atmosphere in a nursing home was more process oriented than person-centred. *“There is a difference in terms of working in a team, because when they have a shortage of staff...they can’t do what they’re supposed to do, because they are trying to beat the time...”*

You see they ignore a lot of things, they will not do it the way it's supposed to be." However, one private nursing home nurse who had worked in a public long-stay ward, viewed the nursing home environment as much more homely than acute settings and thus held more benefits for the residents. In contrast, interview participants who had worked in both institutional and home settings felt that care delivery in private homes was more person-centred, focusing directly on the needs and preferences of the older client.

Regardless of the work setting, the descriptions of older adult care primarily portray a busy, and in some cases, a hectic workload. Again, while this is somewhat related to the dependency level of the older person being cared for, there was a general sense from the interviews that older adult care is demanding, as a care assistant in an institutional setting describes, *"The day - in the morning you come in... you get all about the patients you have and what's the story with them, then you start doing washes, you do breakfast, you feed the patients, this daily routine kind of. Then you make sure they're comfortable, they're sitting out, and then you... hoist them in and out again, because they can sit out for maybe full hour, and then you get [them] back in the bed, you get them out again. Like a bit busy, heavy day, yeah. Because they really old, they need full assistance really."*

A similar level of activity is evident in the descriptions of a home carer, *"Every day I'm working every morning you know, and night-time as well. Every morning I have four ...four ladies you know, so we are given [a] time you know ... So that's the time we have to go there to that specific house, to get her up, if she wants breakfast, or bring her to the toilet, or give her a shower if she wants. Then after that, I'll go again to the other people..."*

The challenging nature of caring for older people was also highlighted. These challenges represent fundamental aspects of care delivery and the caring relationship, which were common to all settings. Manual handling and the demands on personal strength were noted as significant difficulties during the course of the every-day care routine. *"I think the difficulty is lifting, you know... When I came, there was no hoist. That's why they hired me because the old man cannot, cannot look after [his wife] alone... And then it's difficult, very difficult, you know lifting. She is a big lady... And I am small."*

Emotional challenges were also evident. Participants described the stress involved in having to care for people with high levels of dependency and specific conditions. *"Oh it was very stressful for me when I came and I saw what a huge amount of people suffering from such disease... So Down Syndrome, Alzheimer, dementia, strokes, people come after hospital - a lot of people come just for a few weeks, they cannot move, they cannot walk!"* Interviewees also spoke about the difficulty in coping with the attachment they establish to people they care for, both in terms of moving to another client, *"For me, it's very difficult, because if I like people and something happened... for example, I'm getting new job, and if I'm broken a relation with people, it's really not easy"* and in dealing with death, *"There have been instances that I've been attached to older people, when they pass away, I just can't accept it like."*

Several participants noted the additional difficulty in delivering appropriate levels of care to older people who suffer from Alzheimer's disease and the other dementias. The demanding nature of these conditions, and the behaviours that they can induce, were found to be especially challenging when carers did not have previous experience of the conditions. One care assistant who was awaiting nurse registration outlined a fundamental difficulty of caring for older adults with Alzheimer's, *"She able to forget you, she like you now, in a moment, or maybe after a while, she don't like you anymore."* Similarly a more experienced nurse stated that *"For those with Alzheimer's, when they're confused, they're not aware of what is going on, so I mean like it's quite challenging to be with them, and then trying to find out the... how you could arouse some feelings in them."*

Salary, Conditions and Standard of Living

Several participants stated they were happy with the salary and conditions they received for their work. However, the majority of individuals 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 comparison to other jobs. While these concerns differed slightly by sector and skill level, remuneration rates were viewed generally as an area that required attention for both migrant care workers and Irish national workers. In many cases, particularly care assistants working in the private sector, interviewees received the minimum wage or just above the minimum wage for their work. *"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, but I'm working six years already."* For a number of people this rate of pay appeared to be independent of experience and the length of time spent with the employer. *"Some people like they come they getting like for example €9, yeah. It's like I'm working here six years and I was getting the same so I don't think that was the right thing...I was asking two months all the time 'can I get more, can I get more', I got it, but I need to ask them so many times, you know."*

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 as a nurse working in a private nursing home outlines. *"They like the work here, only the salary - they are not giving increments, and they're fed up, that's why they are going."* In turn, the consequences of such turnover were said to directly impact 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 two or three weeks, after that, all the staff is going because of salary problems."*

Distinctions across the public-private sector and work settings were evident in the experiences of a number of interviewees. The standardised wage increments and salaries of the public sector were praised and were significant pull factors towards the public sector. Participants who had worked in both settings praised the transparency associated with the public sector, e.g. salaries increments and internal promotions. Although, some participants who worked in the public sector, especially care assistants; still felt that there was insufficient remuneration for what was described as a demanding job. *"No, the salary's not good, because the service that we provide. The value, you can't calculate."*

Issues surrounding work conditions and remuneration were not felt to be exclusive to migrant care workers and were rarely viewed as discriminatory. Participants, in the majority of cases, did not consider themselves to be treated any differently than Irish carers and spoke about the general discontent across all nationalities, including Irish 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."*

Given the absence of comparable caring roles, there was a difficulty for some in comparing current employment conditions in Ireland to those in their home countries. Nevertheless, participants acknowledged that on the whole the working conditions in Ireland were superior to that in their home nation. *"Oh they are a hundred per cent better! They are a hundred per cent better."* Additionally, people spoke about the security of employment in Ireland and how it provided a greater sense of stability than their home country, which is evident in the statement of one Filipino registered nurse, *"I'm earning a good amount compared to the one that I'm earning in the Philippines. So I was just thinking security-wise...going [back] to the Philippines would never be an option."*

The extra income meant increased spending power in the migrant carer's home countries, reflecting the disparity between the strength of Ireland's economy and that of the migrant nations. *"When you come for holidays, you feel like you are...I don't know...the king...just because you are on holidays, you know, you can buy whatever you want, clothes and food and I'm going straight to the pharmacy, have a full list."* One interviewee described how the relative strength of the additional financial resources allowed capital purchases that would not have been possible before. *"We did buy apartment, but it's just because we were working in Ireland and we could ...my husband actually could manage to save some money."*

For many participants money earned in Ireland was used to support dependents living in their home country. Over 80% of those interviewed sent remittances to either immediate family who may be awaiting family reunification (e.g. parents, spouse and children), or other relatives such as nephews and nieces. In some cases this money funded general costs, while in others it was directed towards specific expenses such as medicines and education. *"I need to support my family... My parents, both my mother, my, my father and also sisters and I have nephews and I send them to school, in college. So I need, I need to support them...Especially medicine of my mother."* For some participants, the financial support being provided to dependents was even more substantial. *"I am planning to build a house for them, for my family, for my parents, for my sister."* The shift hours and over-time available in the older adult care sector were specifically mentioned as facilitating the support of family and friends in home countries. However, for one employer the need to work as many hours as possible to provide remittances was a source of concern. *"[Migrant carers] are working too many hours and you have to stop them...and I can tell you how many staff are now paying for different people going through college and all that...I would have to talk to them 'Look you are doing too much overtime... you can't be doing that' and then I would find out during the course of that conversation that 'Oh I have two more sisters that I am putting through college.'"*

The higher cost of living in Ireland was highlighted as a challenge for the migrant carer interviewees. Not only were the goods and services considered to be more expensive than in participants' home countries, but the proportional cost of these goods relative to people's income was also thought to be higher. Rent for accommodation was a significant drain on a carer's income. *"I came here for one year to make money and I go home. But I didn't make any money, I just borrowed it and took loans and loans! Because it's really very expensive - the bills, rent, so much money."* Health services and health and medical products were seen as being prohibitively expensive. Those individuals who could avail of free health care in their home country travelled home for annual medical examinations and health products. For example, in describing a return visit to her home country a female carer from the Ukraine stated that, *"We're going to do everything - all medical service, dentist, everything, check-up, because it's more cheaper."*

Ultimately though, even with the increased cost of living, participants stated that they were able to achieve a higher standard of living than in their home country. Almost 90% of those interviewed stated that their economic situation was better than before they lived in Ireland. *"I feel very comfortable here...because I know I work, I get money, so I don't have to ask family or any friends...you know I can plan my life, so my daughter is going to school, she's doing very well, we are healthy."* Participants who left their home countries for human rights reasons also spoke about the additional security afforded from living in a safe untroubled country, such as Ireland. This is evident in the comment of an interviewee from Nigeria, *"No, it's better off here because ...There are no rules there...here you know, you work, you get paid...you can be comfortable. Unlike over there, where people just do things. And so much...the comfort, everything is not there. Security-wise, is not there."*

Workplace Relationships

Workplace relationships introduce a complex set of factors that are integral to the integration process of migrant carer workers. These relationships can help to define the working experiences of carers, providing pathways to assist migrant individuals or creating additional barriers that have to be negotiated.

Employers and Other Staff

Many participants described a strong working relationship with their bosses or immediate supervisors and spoke about their approachable and flexible nature. *"She's really very good woman... If I need some help...you know...she's help me. If I have different questions, about change my hours or for example... if I call her, she always agree with me, and help cut hours, or give me hours for other times, for example, for morning time or day time."* For a number of individuals their relationship with their employer extended beyond the working domain and developed into a close and supportive friendship. This was typically related to employers often being the first predominant source of support to a foreign national carer when working in this sector. *"My immediate boss? In fact, I don't see her as my boss, I see her as my friend. She is my friend. I could pick up the phone and give her a call. Oh I don't want to call her name now...I just call her Mary 'Mary I need such and such a thing, can you meet me in the office, or do you want me to put it in the post?' - 'ok' - 'can we go out for a drink or something?' She's that kind of a person. And the husband too, is a lovely guy. You see they are my boss, they are my friends, my family friends."* For other participants, their relationship with their employers was based on the more traditional roles. *"She's still the boss and I'm still ...she's employer, I'm employee!"*

For those participants who were promoted to supervisory roles, there was an added dimension to working relationships, particularly if they were managing Irish staff. Interviewees described an initial apprehension on the part of some Irish workers. *At first they are hesitant... I mean, come on, that's the real reality! When I set forth as a manager down there ...one of the staff told me that she doesn't want a Filipino manager, and then come from August until the present, she doesn't want to leave me, so I've turned 360 degrees her perception!"* Although another Filipino participant did note that there is also apprehension for the migrant carer when taking up such a role. *"At first, at first because you know I'm really shy, I'm just shy...there's still a little...sometimes I forget that I'm a nurse now, especially at delegating work at first, I'm not really 'do this, do that', because as I said, oh my God, I'm a carer. That's before, years ago... But at first I'm a little bit reluctant to tell 'do this, do that', but now it looks like this is your job, you have to supervise them."*

Primarily migrants described receiving significant support from their co-workers, especially when having first arrived in Ireland. Irish carers assisted in orientating people to formal work practices and general care of older adults. *"I was training under an Irish girl when I came over here first time. She was very helpful...She explained everything, each and everything. She showed me first how to do them bed-making, I'm doing the same kind of doing, the same style now."* This support was also in terms of employee relations and workplace integration. For some interviewees there appeared to be a real sense of fulfilment in working with other staff members in care for older people, as outlined by one Nigerian care assistant. *"You meet...you get to know people, you get to know everyone, and at the same time, the treatment as well...we work as a team, so you go home, you feel...ok I worked my day, and you can't wait the next morning, because it's just...you know...the environment, and the staff and everyone, it's just lovely...You feel you are part of the team every single day, because even if it's tough going, even if we have a hectic day, you still have...we still have a laugh, we're laughing and little craics in everything, and it keeps everyone going. The day becomes easier."*

The multiculturalism of working relationships within older adult care environments was also highlighted. The majority of workers interviewed in this study worked in an organisation with Irish and other cultures other than their own. While some interviewees noted that this can pose its own challenges, there was an acknowledged need to be respectful of the needs of others. *“It is challenging, especially as it’s multicultural now, and then they have different cultural...they can go for holidays, extend their holidays because they want to get married - at an instant, but you don’t understand that, but that’s their culture. You have to adapt and accept that, and you have to ensure that your staffing levels are alright, and you have to work with her to the point, so that she can actually facilitate her needs as well. So we have to respect that.”* Another participant described the more positive aspects of interacting with people of different nationalities and different cultures. *“It is an interesting one, but you see the people from different places, and you know their culture, you talk to them, you know what’s happening in different places, it’s really nice to be friends, and know about the happenings around the world. It’s nice actually.”*

Over 70% of employers surveyed stated that employing migrant care workers did not impact on staff relationships. However, responses to open questions hinted at a more complex dynamic. In some cases, this related to the multiculturalism of many care organisations and the employee dynamics within those organisations. *“Integration is a challenge as migrant workers often stick together and are not culturally co-operative with other migrant workers.”* For other employers multicultural integration was not a significant issue and instead appeared to bolster the working environment. With respect to relations with Irish carers, employers highlighted that in most cases Irish staff were welcoming and supportive of migrant carers, often assisting them with respect to orientation and social integration. *“The Irish girls have been quite supportive to them... they were quite helpful...they have had nights out a few times a year and they have embraced them and brought them on with them and include them.”*

Older People

Relationships with older people were multifaceted. In some cases the nature of interactions were defined by the demands of the job, and the physical, emotional and dependency characteristics of the care provision. This was linked to the duties and responsibilities of care work, and the challenges of caring for dependent older people in both residential and home care settings, as dealt with at the beginning of this chapter. That said, there were a number of positive aspects of caring for older people evident in the accounts of the migrant carers. For a number of people this was directly connected to the relationships formed with older people, whereas for others it was linked to positive benefits of the nature of care work and being a care giver. It is fair to say that to some degree, these elements were common to all participants.

Interviewees described making a difference through their work and highlighted the positive feelings that they obtain from helping other people. *“Sometimes you all for them, maybe family could come in once a week, and you be carer, you be friend, you be family, you be assistant, you be everything for them. And ...you feel really confident in your job, and you feel important for them or something, I don’t really know the feeling, but I feel...oh I can help them.”* For some individuals the appreciation expressed by the older care recipients and their families was directly linked to the sense of contribution that they received. *“Maybe because if you seem good to them you know, they will see you are good to their mother or father or brother or something you know. It’s like if they hear that person pass away they remember to get you a card to thank you. It is a nice feeling you know.”* This positive feedback also appeared to foster feelings of accomplishment and achievement, which in turn served to reaffirm an individual’s capacity as a carer. *“When they say you are doing your job well, you feel like you are doing your job well. You feel like they really mean it. And when their relatives say... you are doing a good job, you feel good because you are really doing your part.”*

Other positive aspects concentrated more on the direct relationship with the older person and the reciprocity that appeared to be embedded in the carer's interactions with that person. Interviewees spoke about establishing a strong emotional attachment with older individuals during the process of caring. *"I miss them, I don't know why. If I am at home, I will be watching the clock, I'll be looking...because we have a routine... So if I'm at home, I will just be watching at the clock, and guessing exactly what is going on! [laughter]."* Some participants described the sense of companionship that evolved with older care recipients and how their relationship with the older person had developed beyond service provider and service user. *"Going home for holidays so I am going it's OK I'll see you after 2 weeks or something and he's coming back 'Oh, how you doing I'm back'. It's nearly like friends, you know...it's something different."* Similarly, *"We feel like they are ours like. You feel that like. Now I would miss everybody! [laughter] If I go from here, I will miss so many of them! [laughter] We know each other now... We've formed a relationship - that's the main thing."*

Interviewees also noted that the interaction with older people fostered an exchange of cultural information akin to cross-cultural learning. *"Sometimes people ask me...my friends or somebody ask 'why are you not applying some shopping centre, or somewhere?' - I say 'I don't like that job, I more like speaking with people, learning something' you know because people always tell me about life, or what was before in Ireland, what now. I'm history teacher [originally] - this is very interesting for me!"* In addition to the carer learning about the older person's life growing up in Ireland, the older person also learned about the carer's home country. The following quotation describes one of these exchanges between a male carer and an older man *"He asked me one time 'where are you from?' - 'I'm from India' - 'I know one man from over there, do you know him?' - 'who is he?' - 'Gandhi'! 'He was a good man'. And he is telling like this way, Mahatma Gandhi, 'Mahatma means great' - he knows everything... If you ask the residents, they will know everything about me, how many children I have, how old is they, what is name of my wife, how old is she, everything. Where am I coming from, how long I am working here, everything."* Aside from a simple talking point, these intercultural conversations illustrated that some older people were interested in the lives and cultures of their migrant carers. In effect, this interest appeared to enhance the sense of belonging that a migrant carer felt in their role.

For a number of interviewees, personal growth and development were highlighted as significant benefits of caring for older people. The emotionally laden and intimate nature of care work was described as helping the carers to form a clearer awareness of their own context and the perspective of others. *"It's helped develop me as a person, it's toned me down, understand myself, understand my environment, understand the other person that I'm dealing with really... I've learned from it."* Caring for older adults sometimes enhanced people's self-esteem and self respect. This was connected to the feelings of making a difference described earlier in this section. Participants also spoke about the therapeutic like effect that caring for older people can have. In particular, how the caring environment offers a welcome distraction from daily worries and concerns. *"Even if I've got my own little things, and my own little problems, when I put on my uniform, I'm going to work... I have to leave everything on the doorstep, I have to be...I know I'm working with people, I know I have to be... you know... easy-going, so every morning it's lovely going to work, it is."*

Workplace Discrimination

For some individuals, workplace relationships did give rise to workplace discrimination. There were two forms of discriminatory experiences; those that were explicit or overt, and by their nature more severe, and those that were more subtle or covert and typically less severe. The former mainly related to skin colour while the latter could occur at any time to any migrant carer. Selective recruitment, selective rostering, work team isolation, increased workloads and favouritism were described as some of the negative discriminatory issues surrounding working in the older adult health and social care sector.

Skin colour appeared to introduce an additional layer of prejudice, with a number of African participants mentioning the overt favouritism shown not only towards Irish carers, but towards European Caucasians. One interviewee spoke about the apparent distinction between the criteria needed by African workers to obtain a job, as compared with EU nationals. *"Where I worked first... they ask you what qualifications do you have? Do you have this certificate, do you have this? Then other people [EU nationals] who come in, they don't have anything, no certification, no qualification, and they just take them in. Whereas we're the ones with the certificates, I mean if you have those people beside you, and you are looking for the same job, you just forget about us, we just forget all about the certificate, because they would prefer to take them first."*

This same participant had experienced more severe discrimination in attempting to apply for another job. *"I wanted to make an application to another nursing home, that one would not open the door - actually she talked to me from [behind the door]... 'There's no space, there's no space'. And later I saw adverts in the papers, I applied, they called and said my CV was very impressive, but I'm sure by the time they heard my voice... they never got back to me. And I kept seeing the same advert in the papers week in week out. And I applied twice to the same place."* Similarly, another interviewee recognised the potential for bias against African people, which serves to hamper their opportunities for care employment. *"I'd say...I don't know, there's still a stigma that Africans...like if I'm looking for work - that's myself, that's a Polish, and that's a Latvian, and the Europeans, the Europeans - some of them don't have English at all, but you'll find them working. But people who are well able to express themselves, if they go looking for work, they can't find it, so I don't know what's behind that. I'd say maybe ...you know...there's something going on, but I don't know."*

In terms of relations with older people, a number of carers recounted occasions where residents, or clients, openly favoured Irish workers, dismissing the assistance of foreign national staff. Again, the more severe cases were directly related to skin colour, with carers from African countries experiencing the strongest forms of rejection and sometimes abuse. A nurse working in an institutional setting described one such occurrence. *"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.' "*

These experiences were not specific to care in long-stay settings as a home care assistant highlights, *"Sometimes they give you a client and...once the client sees you're a black person, they don't want you."* The nature of home care delivery, namely individual placements and one-to-one interactions, appears to accentuate the pressures on the home carer to be accepted and thus to work around these issues. *"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, he doesn't want me. You try your possible best, you clean... do what you don't have to do, you mop, you make sure the house is extra clean, you do your work - some of them, if they don't want you, they don't want you."*

In the employer telephone interviews, a small number of participants mentioned that some older adults can exhibit discriminatory behaviour towards migrant carers. A nursing home employer describes one such incident and the role of the lack of cultural knowledge and awareness in the construction of these discriminatory behaviours. *“Really really insulting to these [migrant carers], I worked very hard when they came in first trying to police it, because it was the resident who was abusive to the [migrant carers] and not the other way around...Certainly in rural Ireland, they would be ignorant about embracing all cultures and they have no problem, when their elderly, of showing that dislike...Older people are quite abusive to staff [in general] and these poor girls got a lot of abuse from them.”*

More subtle forms of favouritism towards Irish staff were also described. One Filipino nurse commented that the shift roster appeared to be engineered for the Irish more tenured employees. *“I get those days that they don't like to work, like the weekends. I say ok [laughter].”* This also referred to supplying cover when staff parties are organised for all employees. *“I do participate on staff night out, but usually I am the one left to work...so that's how it goes. Like Christmas party, I will be the one who will be on night duty.”* The participant did state that she did not explicitly object to the work schedule, feeling that she neither had the courage nor the length of service to be able to do so. Nevertheless, this interviewee also highlighted that her scheduled shift hours were often cut with no notice. *“Sometimes if I am on 8 - 4 morning shift, sometimes if there are 4 or 5 of us in the house they say you can go home at 2pm... But [the manager] is not doing it to the rest of the staff, he is doing it to only me saying 'we have loads of staff now'... But I say oh, 'I don't want these things to happen again, because in two hours time, I have no where to go because in my mind I am set up to work.' But still it happens again and again and again and again.”* Another carer mentioned that foreign workers appear to be ignored in preference of Irish carers, *“At times we do find that some of the things is not heard that we say, whereas it's more preferences is given to Irish staff as well.”*

In some cases, staff relations were the source of negative experiences. One individual described how foreign workers appeared to be left with the majority of work to complete. *“Some of these Irish people... might like to leave some work for you to do it all, yeah... maybe because you're a foreigner. You know sometimes because it's group work, it wasn't shared, maybe you have to do this, this, this you know.”* A care assistant highlighted that in a past experience, Irish staff did not seem to want to work with migrant carers, *“I worked in the nursing home, for my work experience. Yeah, I knew then that some of the staff would not want to work with [me]... I wouldn't categorically say what is their reason. But sometimes I tend to think, maybe because of my skin colour.”* Conversely, another interviewee noted that Irish employees sometimes question the capabilities of migrant carers and undermine their non-Irish experience, *“Because sometimes when they look at us and we are non-EU they say oh gosh you are not trained to do this kind of job. Or you cannot do this job well. I choose this one person other than you. So its still things that are not clearly defined, like we get less chances of being chosen as good, as the rest of the staff.”* In one instance, this tension appeared to be so strong that an employer appeared to be dissuaded from employing migrant workers, *“She told me that actually the lady who runs the place says because an Irish girl refused to work there because there were black carers there, and that is why... she wasn't taking anymore.”*

Although only 9% of employers surveyed stated that staff relations became worse after employing migrant care workers, comments to open-questions did highlight that staff relations were a concern for a number of respondents. Employers referred directly to the relationship between Irish workers and migrant carers. *“Irish staff in general seem to prefer to work with other Irish staff. They do not seem comfortable working with non-Irish staff. Maybe this is why some of them leave.”* In other instances the difficulties were said to be more direct and discriminatory. *“I have found that a lot of discrimination is shown to migrant colleagues.”* In the employer

telephone interviews, participants spoke about comparable issues, where migrant carers were not always trusted or welcomed by Irish employees. This appeared to be linked to perceptions of foreign nationals not having suitable levels of training. While in other cases it was connected to the number of hours that migrant workers were willing to work.

Additionally, the role of the families of older care recipients in discrimination was highlighted. A registered nurse from India described how some relatives inappropriately question the credentials and the capabilities of migrant carers, *“Some families having really problems, really challenging like - they doesn’t like us, we are from another country, we are from India... You know they are just giving out to us ‘where did you study?’, ‘where do you came from?’, ‘some rural areas, you don’t know anything!’ In front of us like we have really bad experience.”* While a Ukrainian care assistant mentioned that, *“Even... a visitor of our patient, she says the same ‘bloody foreigners!’ - they always feel this.”* A registered nurse from the Philippines stated that comments by relatives overstate the issue and can be difficult to cope with, *“Yeah sometimes like ‘my mom likes chicken and gravy, but you don’t know about chicken and gravy do you?’ I say ‘oh yeah we always eat rice so I’ll ask her what she wants.’ So it is hard sometimes because the family members is exaggerating situations or different situations sometimes.”*

Home care settings were noted to be problematic when live-in carers were directly employed by an older person, or their family. The sensitivities associated with being dependent on one person for work and accommodation seemed to generate an unfair power advantage for the employer. The complexities of being in a completely private environment just served to confound these issues. *“Because the only thing I don’t like the old man is he is very, what do you call that sometimes? Aggressive...what I don’t like is someone who will shout at me...But anyway I told him “Don’t shout at me. Kindly, please talk to me in a nice way.”* The boundaries between work and leisure did not appear to be clearly defined. The carer’s working hours or their physical and private space within the home was not always clear, compromising the overall autonomy of the live-in carer. *“So I ask him if I can, if I could go but anyway it’s, it’s my off day. But the reason why I ask permission because my friends from very far place, from Galway, from different, from Cork... we want to stay in that house, in my employer’s house. So you know what he said ‘ok, you can bring your friends one at a time, but not many.’ It’s very hurting, you know.”* While only three interview participants had worked as live-in carers, these descriptions provide some insight into the difficulties that can sometimes be associated within live-in care.

It was clear that people who suffered discrimination from employers or other staff were distressed by their experiences. After receiving derogatory remarks because of gaining a promotion, one registered nurse felt so upset that she decided to leave her job. *“I was very unhappy, because when they are thinking... that you are going to become the CNM [clinical nurse manager] soon - they are very jealous like you know. They felt in that way, and they treated me that way, so I felt very bad, I thought it better to go away.”* In describing her reaction to discrimination a care assistant commented that, *“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, it’s not part of me to say...I have been working before, 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.”*

Likewise, the impact of discrimination perpetrated by older clients, or residents, was clearly hurtful to interview participants. People spoke about the initial shock and dismay when first confronted with such attitudes and behaviour. While in some cases, the incidents arose from the first interaction with an older person, in others the comments came from someone that the carer had already built a relationship with. Understandably, these later incidents proved to be the more upsetting, *“I don’t see myself as black, I just see myself as a human being, as a care assistant, so if the bell rings, if I walk in... you don’t expect to be told ‘you are black’. It was kind*

of a shock, because I was like 'oh no!' I swear to God, I shed a little tear, I went into the bathroom and I cried because I said to myself... this lady I loved her, but I didn't expect that something would come out of her mouth of saying 'I don't want you near me, you are black' - I didn't expect that." However, it was recognised that these explicit incidents were the exceptions rather than the rule. It was also acknowledged that this type of derogatory behaviour was sometimes connected with cognitive impairment of the older person and may not have reflected the older person's true feelings.

There appears to be a connection between some of the more negative employment experiences of migrant carers and their first position caring for older people in Ireland. A live-in care worker stated that, *"The first... they exploited me you know the salary is not good... they not following the law yeah and then my type of job, it is not, it is type all around everything and my time it is not right time you know it is overtime. I have a lot of work over time you know."* Participants spoke about the uncertainty surrounding their employment conditions and their susceptibility to exploitation during this period. *"After dinnertime we had to secretly take food from the kitchen and hide somewhere and eat our food quickly because we didn't have a break and there was a shop but we were not allowed to leave the house."* These experiences seem to be related to the disorientation of moving to a new country, characterised by little information on labour rights and entitlements, a lack of knowledge of support organisations and few social networks. *"It took us a year to know that we should have a break... We really thought, oh, this is the Irish way of working... So we have no friends that we could ask about this, because we are all living in the same house, but we are renting one room from the nursing home. So we do not know one thing about Ireland, the culture or rights, nothing at all."* The vulnerability of these individuals was enhanced by the fact that the employer had arranged their migration into Ireland and supplied their accommodation.

Many migrant carers reported that much of the difficulty surrounding acceptance by older people was concentrated in the initial period of care delivery, as described by a Filipino care assistant, *"When we were very new you know, there was even one old person... he won't take the tablet, because it's the first time that the foreigners are working in the nursing home. So he was thinking that it's a poison."* Issues surrounding trust and carer preference occurred frequently during this period. *"They don't trust us at first. They say 'oh I want [Irish care assistant]... So even though I am a nurse and she is a care assistant, but she is Irish so they say 'I want her'."* However, there was recognition that older adults had little experience with foreign nationals. A male Indian nurse commented, *"She [an older lady] never mingled with a foreigner - she doesn't like actually... I can't blame her because she never had that experience before. So it's not her fault actually."*

Participants noted that many difficulties subsided with time, after a trust had been established between carer and care recipient. *"If the patient is new she wouldn't trust me. She still has the preference to ask things from the Irish staff. But once you get that they know you well and that you give good care... that's where trust starts. Because it's hard really to establish trust at first. They say 'oh no, you don't know what I want, you don't know what food I want to eat.'" Similarly, discriminatory remarks made by care recipients' families were strongest at the beginning. "Yeah, at first they said 'oh, you are not Irish' and then after time goes by, they say 'oh she works, she minds my granny well' so they realise it's not the colour of your skin that matters, its how you are."*

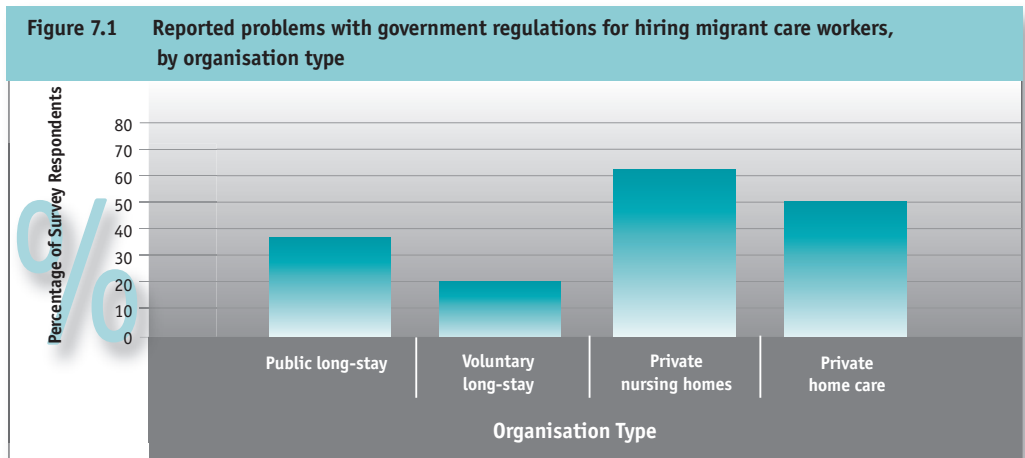
A number of the migrant carers described how they felt they needed to prove themselves in their role. In some instances this arose from experiences of discrimination, while in others it related to the questions around their capabilities as carers. *"There's kind of...you know...I wouldn't say pressure now, it was pressure before when I started, because I had to prove them that I am a carer and I can do better than Irish themselves! That's what I had to prove! ...and when they get to know me, ok they say 'she can really do it', but if I didn't prove myself, I'd be out on the road still looking for work. Isn't that the case?"* Proving oneself was not just in terms of gaining the confidence and respect of employers and other employees, but it also referred to gaining the trust of older care

recipients. Some participants chose not to assert themselves within the work setting and instead decided to adapt around the work practices and behaviours of others. There was a sense of ‘not wanting to rock the boat’ and jeopardising their job or their working relationships. For instance, one nurse speaking about her issues with roster hours commented that, *“I say nothing at this time. I feel after I have been here more years, I say I don’t want this job, I want Friday off or Sunday off. But not at this time, no, I can not say that at this time. I say yes.”*

Immigration and Employment Regulations¹⁶

Immigration and employment regulations impact not only on the migrant carer and their experiences, but also on the experiences of their employers.

Over half (56%) of all employers surveyed had experienced problems with government regulations for hiring migrant care workers. Private nursing homes reported more difficulty with government regulations than any other employer type. Employers in the voluntary long-stay care sector reported the least problems with regulations (see Figure 7.1).

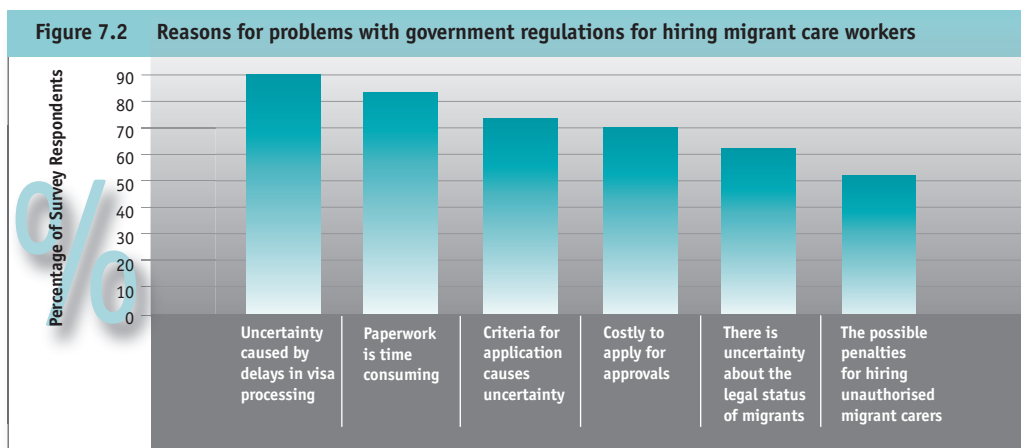


Source: Employer survey

NOTE: Public long-stay = HSE extended care units, HSE welfare home, HSE district hospital and HSE community hospital; Voluntary long-stay = voluntary geriatric hospital and voluntary geriatric home; all other categories as listed.

■ ¹⁶ Dr. Adeline Cooney, School of Nursing and Midwifery at NUIG, contributed to the writing of this section.

Figure 7.2 shows that uncertainty caused by delays in visa processing (89%), time-consuming paperwork (84%) and uncertain application criteria (74%) are key issues for employers. Almost 70% of employers said that the necessary approvals were costly to apply for, whereas just over 60% stated that uncertainty around the legal status of migrant workers was a problem. Fifty three per cent of respondents said that possible penalties for hiring unauthorised migrant workers were a concern.



Source: Employer survey

Survey respondents expressed difficulty in understanding why there were such restrictions on employing migrant care workers in Ireland. *“Well trained and reliable workers often find difficulty [in] applying for work permits.”* One employer appeared to be genuinely frustrated with government regulations and the predicament that migrant carers find themselves in. *“The main disadvantage is from the Department of Enterprise, Trade and Employment because of red tape, length of time to process work permits and basically putting obstacles in their way. The inhumane way they treat the families of migrant workers. You would think they would accommodate them more easily given that they are shoring up the disastrous Irish health care system.”* Another respondent highlighted that the spouses of migrant carers find it very difficult to get work, which is problematic for all members of the family. *“The main disadvantage I find is employing non-EU workers and hearing the difficulties they face in job procurement for their spouses. This is particularly evident in employing Indian nurses.”*

Employers in the telephone interviews again highlighted the levels of bureaucracy involved in applying for employment permits. The effectiveness of the current process and the efficiency in which applications are processed, rejected and appealed came under question as one interviewee describes. *“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.”*

Because of the salary restrictions on work permit applications (salaries must pay €30,000 or more) under the *Employment Permits Act 2006* and under the revised arrangements for employment permits introduced in June 2009, in effect only registered nurses were recruited from outside the EEA. A number of employers called for open labour market competition as a means to improving the quality of carers that are recruited. Currently government regulations require that 50% of staff must be from countries inside the EEA. This restriction is

thought to limit the pool for migrant recruitment and thus limits the quality and suitability of carers that are being employed. Having to prioritise EEA nationals over other migrant carers for available posts, as specified by employment regulations, is thought by some employers to compromise the effectiveness of the health and social care system.

Participants wanted to hire the best candidate possible and not have to forgo the most suitable person for the job because of regulations and favouritism towards EEA nationals. *“What really irritates me is the fact they [Department of Enterprise, Trade and Employment] don’t make it easy for us in getting staff. We are forced to take these people on, when there might be other people out there who are more qualified, more suitable... If you go for a work permit...we would be bringing them in because they do have some sort of nursing qualification or do have caring background and come from that angle. But they won’t allow us to employ them or take them in until we can show that we cannot get any suitable Irish or [other European nationalities].”*

For the migrant care workers, employment status and immigration status are intertwined, with many of the issues mirroring those raised by employers. Interviewees focused on the employment permits system and in particular on the regulations concerning work permits. Overall, and as experienced by employers, the restrictiveness, the bureaucracy and the delays associated with application processing were the fundamental issues. Participants mentioned that some employers are not willing to apply for a work permit due to the perceived difficulty in negotiating the system. A male care assistant stated that he could not find work in his original profession as an accountant because of this problem. *“In my case, they are not waiting for me, they will get another man anyway, without any work permit.”*

Moving jobs through the work permit system was a significant issue. Delays in the application procedure and the additional delays caused by denials characterised descriptions of this process and the feelings of being caught in ‘limbo’. These problems became more serious when a carer was attempting to leave an exploitive or abusive 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... That was a big problem. We had to reapply for our work permit from our first employer but once you transfer to the next employer it took me three appeals because it was denied the first time.”*

Being in ‘limbo’ created a sense of insecurity and uncertainty, to the extent that sometimes participants were afraid to move or to ask for their entitlements because they felt insecure about the status of their work permit. *“[In my first job]... the employer... accepted me through internet, but you know she’s not nice... she’s not really nice to Filipinos. It was like maybe racial discrimination, but she’s not treating us well...I stayed there for nearly three years, because you know... I came pregnant, and I’m afraid...you know I have maternity leave afterward, I’m afraid to look for another employer, because I still need a working permit at the time.”* As a consequence employment permit regulations could in actuality function to keep migrant carers in vulnerable situations. Similarly, the requirement to remain with an employer for a definite period of time (two years for a work permit; one year for a green card) was thought to enhance the carer’s susceptibility to exploitation. *“Say if I came in a green card, and I had been put in a nursing home by a recruitment agency, and if I don’t like the settings and the surroundings in the nursing homes, still I can’t move out, because I have to be there for a year - if it’s a green card.”*

This was in contrast to the experiences of one employer. The requirement to stay with an employer for at least one year (two years for a work permit), was seen positively and as a means of maintaining a continuity of care. *“When you have migrant workers, you get at least a year out of them. They come in on work permits mostly... you have some continuity [of care] then.”*

Migrant carers also noted that the favouritism shown towards EEA workers for vacant positions hindered their employment opportunities. For one individual, this criterion was cited several times as grounds for denial of an employment permit, *“Because they [Department of Enterprise, Trade and Employment] said oh, we want EU countries to fill in this vacancy then it was appealed again... and it was denied again. And the third time really [the employer] said we want this person because she is a nurse and we want her to finish her adaptation to work with us as a nurse so at that time it was approved.”* Therefore just as employers expressed concern about the requirement to hire EEA workers, with respect to the quality of recruited employees, migrant carers found that it impinged on opportunities for employment and advancement in older adult care.

Additionally the restrictiveness of this regulation was said by one participant to be directly related to the rise in undocumented workers in the care sector. In effect, when a carer is faced with the reality of having to return home, these regulations appear to foster, rather than protect against, undocumented labour. *“We actually have loads of undocumented Filipino workers here because they came here with a valid work permit. As soon as they move from one job to the other they are denied.”*

Issues around family reunification and pathways to long-term and permanent residency had a significant impact on the lives of migrant carers and their ability to integrate and feel at home in Ireland. For that reason these aspects of immigration regulations are discussed in the next section, among other factors, in the wider context of living in Ireland.

Living in Ireland

There were two distinct themes underlying the participants’ descriptions of living in Ireland. The first focused on whether or not people felt welcomed into Ireland, whereas the second centred on the level of integration that they had achieved since arriving. Overall the participants’ experiences were reasonably positive. That said, once again there appeared to be a difference between the experiences of some African people, who mainly entered the country through the asylum process, and other individuals. While not always directly attributable to racism, the behaviour of some Irish people was interpreted as discriminatory and unwelcoming. This was particularly distressing when the behaviour was directed towards a participant’s family. *“I remember where I live, there was this neighbour we used to have. Even when the children come out and say ‘hi’, they wouldn’t answer. So sometimes I look in case there is danger, something is happening. People [who] will not answer you ‘hi’, will they come to your aid? ...they are kids. It’s not something we should be stressing on them now. Let them grow and see things the way they want to see.”* Another interviewee described the difficulty in finding accommodation when first living in Ireland. *“I was looking for a house, I find it so difficult. Some of them, they don’t like giving foreigners...I would say giving blacks, not foreigners, because they would even prefer to give a Polish person a house than we blacks.”*

However, both of these participants did note that these behaviours did not characterise Irish people. In the first case, the interviewee went on to comment that *“There’s the other set of neighbours... they share the house, in the summertime they come out, when my kids are out, they bring out football, and ask them to come out and play, you know...so when they see those guys out, they want to go out, they’re not the ones that won’t answer.”* In the second case, the participant spoke very highly of support organisations, such as the Citizen’s Information Board, in assisting with accommodation and other formalities when first granted leave to remain in Ireland. Responding to whether being from Nigeria had affected her everyday experiences, this interviewee also commented that *“It didn’t affect me, rather it promotes me!”*

In addition, negative experiences of living in Ireland were not common across all African participants. *“I mean most Irish people are welcoming, to be honest with you. You know you call around...I mean like where we bought*

our house now, it really feels like home, because the neighbours and ...we all know each other, and it's just lovely." Although having experienced the distress of being smuggled into Ireland, some participants described a strong sense of being welcomed. *"For me? No! It wasn't hard for me... I was staying with the hostel, and the management there wasn't harsh, you know whatever I wanted... So then when I moved into my first house, my landlord was a pastor, he's brilliant. And when I moved from there, the second landlord was like...oh Jesus! Even 'til now they still call, '[participant's name] are you ok, have you any problems?' 'If you need a reference, just give them my name'. So all I do when I go to a different place and I need a reference, all I do is to give the name and number, call them - all Irish people."*

A more complex set of factors appeared to influence participants' experiences of integration and belonging within Irish society. While recognising that there is an improved standard of living in Ireland, a number of individuals commented that they did not truly feel at home. For some, this related to their strong intrinsic connection with their home country and its culture, as one participant from Zimbabwe describes, *"You know where... really you come from, you never forget it! It's like I spoke with a few Irish at work, and they will always say 'I lived in England for fifty years and of course I had to come home!' There's nothing like your own home, so I can have my house, and have nearly everything but still there's something that's missing, that's your own home soil, you know what I mean?"* For others, the absence of family detracted from the sense of home associated with Ireland. This is evident in the comment of a male carer from the Philippines, *"One thing there is that being home is being with your family and your relatives, and they're not here. So...I can't feel at home here, because they're away from me... We have friends here, but... making this at home... maybe I can work here, I can stay here, but I have to go home, for a while, for a holiday maybe, for just a holiday."*

The absence of family, and thus the lack of a sense of home, was connected to issues of family reunification. One participant who had hoped Ireland would become her home commented that *"We are allowed to get our children only for minor status, but once they are aged eighteen or above, we can't get it anymore. So say, for example, much as I love it here now, to be honest, I love it here, as I've been saying, I'm content with my job, but what makes it difficult for me is, if I stay here, what about my children?"* Dependents' access to employment was also mentioned by this individual as an issue. In addition, concerns about long-term residency appeared to compromise integration potential. Under the current circumstances the status of many migrant carers was viewed as unstable and *"a more secured life"* was required to make Ireland home. *"Give them the opportunity to become immigrants down here, because you are short of nurses, and they can help you. The thing is we also wanted a security blanket for our family. You know waking up every day thinking that we're accepted in Ireland, we're a part of Ireland, and thinking that one of these days, we would wake up... even if we don't have our job, we can still find a job, because you're actually a resident."*

At a more practical level, the demands of older adult care and a full schedule of working hours appeared to restrict some of the interview participants in the frequency and quality of their social and community interactions. One participant described simply not having the time to engage in social activities with their current workload. *"There is no chance to go out, I am working here for all the days around, seven days in two weeks."* Whereas another interviewee highlighted that the nature of caring for older people can impact on the energy resources for personal pursuits *"It's a stressful work! [Laughter] It's a stressful job, so for me to come back and lift up my bag again, or to drive out somewhere out of the house, it's like I'm adding stress on top of what I have, so I need to sit down and relax my brain... so I prefer to stay at home."*

The bond within migrant ethnic communities was clearly evident. The social and personal lives of several participants seemed to revolve around their own culture and concentrate solely on their home country networks. For example, one Filipino care assistant mentioned that *"It looks like because we're used to Filipinos,*

it's only in working. But if you go out... It's mostly Filipinos." However, a large number of participants appeared to reach a balance between this bond and connections to Irish society, describing a strong sense of integration in living in Ireland. In some cases, people spoke about the contentment they felt with respect to Ireland as a home for them and their families. One Filipino care assistant stated that, *"I am happy here you know. First, the people have a good heart you know. I like simple living, as long as people have a good heart you know. So I don't mind."* Other descriptions focused more heavily on social and support networks and elements of the Irish culture that have been assumed. *"I have Irish friends! Well...I don't really drink before or socialise that much! I learned how to do it here, I learned how to put my feet up, I learned how to go out...And sometimes I go for a walk. I don't usually go for a walk in the Philippines, I never had that before! But I learned to do that here, I learned to adopt what they are actually doing here."* The understanding embedded within these relationships was particularly highlighted. *"Like one of my Irish friends... like on Christmas, she knows that we might be missing our own family, so what she is doing, she is inviting us in their house, and for the night!"*

In addition to general social contact and neighbourhood interactions, a number of pathways that fostered social integration in Ireland were specifically mentioned. Firstly, while work experiences and wider social interactions were already noted to be closely related, successful employee relationships appear to also engender stronger social and personal networks. *"Like for something at Christmas party yes... it's like we...went for drinks and later went for clubbing. It was Irish, West Indian, Polish, Lithuanian...and it's not first time like that you know. Sometimes we meet and some weekends we go out."* Secondly, school activities and children's' social networks were credited with helping people to mix with and integrate into local communities. *"I'm sitting down and getting a cup of coffee, and chatting to the other mummies, and friends, and that's the other way I get my friends."* Finally, participants mentioned church and support groups, such as 'mother and child' meetings, were a useful means of meeting people and building a stronger sense of belonging to Ireland. Voluntary activities were also highlighted in this regard.

While integration may not have been obtained in the form of a definite outcome, participants recognised that feeling a part of Ireland was a process and highlighted how such channels, along with the particular nature of the caring occupation can nurture these feelings. *"Every day I'm integrate more, yes. Every day maybe slowly, but anyway. My kids go to school...I more speaking with Irish people, and parents in the school, and working with old people... old people have some kids or somebody, and it's very good job really for integration."* Although connections to a person's home country were never lost, connections to Ireland appeared to strengthen over time. As one male participant from Lithuania highlights, Ireland has moved beyond a simple site of work and is now more akin to a second home. *"It's like actually my friends was asking like I will fly from Ireland to Lithuania, how you feel? ...It's like I feel like... I go from Cork to Dublin or to Limerick... for example if I go home it's like I know when I'm coming back from Lithuania to Ireland 'oh, I'm home again!'...Yes, two homes now."* This is reflected in the fact that over 85% of participants interviewed said they would still be living in Ireland in five years time.

Older People and Migrant Carers: Perceptions and Experiences



*"We have a resident here just inside the door
and she is Church of Ireland; the first thing,
the first night the Indian nurse came in she says
'You are very welcome to the Parish!'"*

Long-stay employer speaking about the reaction of one resident to a migrant nurse

This chapter explores the impact of employing migrant carers, and related factors, on the lives of older people and the quality of care that is provided. The findings presented in this section are drawn from each of the principle data sources, namely the migrant carer interviews, the employer survey and telephone interviews and the older adult focus groups. To provide a backdrop to the findings concerning older adult perspectives on care, the views of the focus group participants on a multicultural Ireland are first presented. Factors that are interlinked with and can influence the quality of care for older people are then explored. These include issues surrounding language and culture, older adult experiences and acceptance, perceived differences in care provision across care settings, and the impact of employing migrant carers on the quality of care.

Ireland as a Multicultural Society

Both community-based older people and nursing home residents recognised the valuable contribution that foreign nationals were making to Irish society. The work ethos of migrant workers was especially credited, particularly that of Eastern Europeans. People also expressed admiration for individuals who saved money to establish their lives in their own countries and/or sent remittances home to support family and friends. *“There was a Polish girl...she worked for four and a half years and every hour overtime and everything she could get... she bought a house back in Poland and after four and a half years she had her house paid for and she was going back and she was going into university.”* It is in this light that comparisons were made to the Irish history of emigration and the similar efforts of immigrants from Ireland to support those at home, as one nursing home resident described, *“All our people went out to England and went to America... my goodness if they hadn’t been left in, where would we have been? We would have been a lot poorer... isn’t it their money that really brought us up.”*

While labour migrants followed a more formalised channel of entry, some community-based focus group participants acknowledged that the subjective nature of ‘human rights’ led some people to question the sincerity of asylum seekers. For a small number of individuals in the group, this unease was linked to perceptions of system abuses and the benefits that asylum applicants were supposed to receive. *“I think the vast majority of them, they’re trying to pull the wool over our eyes.”* Nigerian nationals, and in the past Romania nationals, were specifically mentioned in this regard. The wider group recognised that these occurrences, along with conjecture about participation in criminal behaviour, could not be generalised across an entire culture or nation. In doing so they highlighted the negative effects of media spin and the absence of entitlement information. *“I think the media present the bad eggs of any culture... I mean... a lot of things in the paper...crime related incidents... and because of that we have a perception of how some people are.”* A participant also remarked that *“The colour of skin can add an extra level of malice from an Irish person’s perspective.”*

Both community-based older people and nursing home residents viewed the influx of migrant people as holding potential social and cultural benefits for Ireland. *“I think I like to understand other people’s cultures as well as our own.”* Community participants highlighted that our inexperience of other cultures may hinder our ability to capitalise on the diversity and achieve integration. *“I think... in your life if you have been mixing with all different people, different countries, you wouldn’t mind, but its people who haven’t. There are people... who have never met a coloured person in their lives and they would have an attitude.”* Although it was acknowledged that Ireland’s history, and older peoples’ experience of emigration, should facilitate a more tolerant outlook, there was doubt over whether this would actually happen. Conversely, nursing home residents thought that this experience had influenced our perspective, as one person remarked *“I feel that because we have always been immigrants anyway... it’s nice to think we can sort of [cope] in the reverse now...you would probably resent people if you didn’t have that experience.”*

Language and Communication

Language and communication, and the interconnections with cultural understanding and perspective, emerged as a significant issue for the delivery of older adult care by migrant carers. This was consistent across employers (see Figure 6.6), older people and migrant carers themselves. To an extent, these difficulties appear to confound some of the other issues that are encountered in the sector.

From the migrant carers' perspective, language and communication was thought to be a considerable problem in the delivery of older adult care. Migrant participants in the study spoke about the necessity for adequate communication between a carer and an older person, *"I believe communication is the first and foremost essential thing to have in dealing with others...it's the most important thing you know - communication."* The barriers that can arise from poor language proficiency were described as altering the dynamic of the carer's relationships with older people and complicating the otherwise routine exchanges. *"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."*

In the case of the employer survey and the employer interviews, poor language proficiency was perhaps the strongest issue to emerge from responses to open questions and from interview discussions. *"I think communication skills is the biggest concern I would have. Because they [migrant carers] speak too low, the residents are half deaf and their nervous when they come in and I think the communication really would be the major thing."* Similarly, *"[Migrant carers] are very keen to work and very keen to learn, but the biggest hurdle they have is communication. And elderly people being elderly people, communication is a huge area."* One survey respondent noted how language problems are inherently connected with the various skills required from carers. *"Many of our nurses are very academic and have the knowledge but lack the basic skills e.g. interpersonal skills, communication skills, listening skills. Residents get frustrated trying to express their concerns, and also cannot understand them."* The implications of such problems were not isolated to the carer and care recipient relationship. One employer mentioned the extra pressure that is placed on other staff and the difficulties in working in an environment where there is a potential for miscommunication. *"Strain and stress added on trainers. Migrant workers can say they understand and in fact on demonstration do not - dangerous."*

Migrant carers also described the complexities that regional accents and colloquialisms introduced into conversations. These intricacies even caused significant problems for individuals who are considered to be from nations with high levels of English proficiency. This was mentioned by one carer from India, *"In India, I was watching the news [in English], and I can understand what they were speaking. After coming here, I never know what they're speaking - their accent is different. I plan to do other courses."* A clinical nurse manager from the Philippines had a similar experience when first dealing with Irish staff, *"The accent from Cork - a real Cork accent! That was actually my training ground to speak...I said 'Oh my God, if people are like this, all of them are like this! How will I communicate?' I couldn't understand."*

The additional difficulties of localised and regionalised language were also spoken about in employer telephone interviews. Interviewees provided many examples of misunderstandings as a result of older people using, what they would consider, everyday terminology. One employer described how a migrant carer had interpreted a female residents' need to *"spend a penny"* as a request to go shopping. Traditionally, this term would be used to refer to having to use the toilet. A small number of foreign national carers highlighted that regional differences can go beyond the bounds of the English language altogether, resulting in issues of trilingual communication. *"In that first nursing home... I think two patients that had no English, only Irish because..."*

one's from Connemara and one's from Aran Islands, so that's really a big difficulty! Because they're telling us Irish, but I don't know, it's really hard." This was supported by a comment to an open question in the employers' survey. *"Older people are not able to understand. Some residents only speak Irish Language."* A migrant carer participant noted that it was not just with respect to face-to-face communication that language proficiency can pose a problem, highlighting that *"Getting some pronunciation, especially through the phones"* is particularly difficult. Again this was supported in interviews with employers, who recognised the operational difficulties concerning telephone communication with external medical staff and families.

For the most part, migrant carer interviewees described the initial period of working as a carer in Ireland as being the most difficult with regards language and communication. Half of the participants interviewed described their proficiency in the English language as poor or fair on entering Ireland. The majority of participants acknowledged that many of the issues were a function of time, and experience, with eventually some of the difficulties subsiding. The role of other employees in assisting new carers to adapt to the language environment was evident. For instance, one participant mentioned the benefits of observing how Irish staff spoke and communicated during the course of their duties, *"[We] just assess what the nurses want you to do first, its good for us because we need to listen how things are being said. And how to understand what they want... because we need to understand what they are talking about, but it takes time for us to understand."*

Another individual outlined how informal language orientations are often given to fellow migrant carers, *"So when the nurses come, say for example, a relative of mine came, ...I gave her an orientation like this 'this is how it's pronounced,' 'so this is how they call it 'a penny for your thoughts!',' 'I want to go to the loo.' [At] first we don't [know] what is the 'loo'!"* Older people were also noted to assist in linguistic learning, which is clear from the description of one older lady's intervention, *"One old lady told me... 'I have to understand you, you are not speaking English, your mother tongue. I am speaking in my mother tongue, you are speaking in my mother tongue, so I have to correct you, if you have any mistake while you are speaking... this is my duty.' So they're thinking like that, that's a good thing you know."*

Whether discussing Ireland as a multicultural and integrated society, preferences for care or being cared for by migrant carers, the importance of language and communication was a unifying theme through each of the focus group discussions with older adults. At a general level, the community-based focus group highlighted the barriers that communication difficulties can cause with respect to the service industry, integration and care provision. Dealing with people in shops, restaurants and other services with poor English proficiency was noted to frustrate simple errands and activities. *"As regards service anywhere... it's a big fault in service... if you're dealing with a migrant ... they don't understand you and you don't understand them."* The feeling was that without appropriate language skills foreign nationals were more likely to revert into their own communities, compromising social and cultural integration. *"Without knowing English, they are driven back into their own little ghettos and then their social skills, or their socialisation skills are not developed. They can't be developed because of the language barrier."* Some nursing home residents also raised this issue, *"I think we are all inclined to go into ghettos... Irish people seem to stick with the Irish, etc."*

The importance and sensitivities of caring for older people only served to exacerbate such problems. Being able to understand each other was seen to be fundamental to the carer-care recipient relationship and was viewed as key to fulfilling not only the needs of the older person, but also in providing a sense of security and belonging to the carer. The social aspect of older adult care and the benefits of a simple conversation were noted by one focus group participant. *"I remember going into a nursing home to see an old lady... and she was confined to her room... she had this foreign national girl coming in, who was very good to tend to all her physical needs, but she*



wasn't really able to communicate and I think she missed that. Do ya know how the Irish girls would come along and they could hone into them and have the same ways and... a better understanding."

Employers also highlighted this need for a balance between foreign and Irish staff for reasons of communication and cultural understanding. *"You need to have the mix right...for example, some of the units in Dublin... there are a 100% non-nationals working in units... I do know that some of the older people have expressed difficulties that they have nobody to relate to in a lot of cases. There is nobody to talk about things in the past of a similar culture, because some of these people [migrant carers] their English is not good and the patients feel they can't relate to them."*

The nursing home residents stated that language proficiency was the greatest difficulty with migrant care workers caring for older people. *"I think the people from other countries, sometimes it can be very hard to understand them."* Although the problems were said to be greatest in the initial period of working with a new foreign carer, issues surrounding basic communication often persisted throughout the relationship. However, participants did speak about the adaptive strategies, such as sign language, that both the carer and the care recipient use to convey a need or instruction. The group described how quickly some of the migrant care workers were able to learn what people required and preferred. *"There was one girl came into me... I asked her to bring me over the tea-towel... finally she picked it up... and she said 'Tea-towel'...so she says to me 'I'll remember that'."* For that reason, while communication was certainly an issue that nursing home residents wanted addressed, it did not seem to impact on the participants' well-being or cause them significant distress. *"A small bit of difficulty with the language, but we get used of that - their way of expressing themselves."*

Migrant care workers speaking in their native language in the presence of the residents was a source of discomfort for some older people, and led to feelings of distrust and being disrespected. This was especially true if the older person was alone with the carers. *"For example now, if someone was given you a shower and someone of the foreign workers walk in and they start chatting among themselves, and you wouldn't have a clue what they're saying... instead of holding on until the shower is finished and then carry on with their conversation. I find that very annoying."* The community dwelling participants and employers also highlighted this behaviour as being inappropriate and problematic. Employers felt that such occurrences generated feelings of unease and distress for an older person receiving care. *"One of the big problems is speaking their own language in front of...the older people... which is not good."* While for staff, people speaking in their native language appeared to compromise workplace integration. *"At break times you will find people speaking their own native language...You'll find each country, or whatever, has their own [group]. The Filipinos, if there are a lot of them together, would tend to revert back to Filipino [language] and you have to keep an eye on that you know, just to make sure that they are cognisant of anybody else who is in the room."*

Culture, Approaches to Care and Work Ethic

The connection between language and culture with respect to traditions, histories and socio-cultural practices are difficult to disentangle – particularly in the close-knit context of the caring environment and caring relationships. While some of the communication issues that emerged from the data analysis are a function of this entanglement, e.g. colloquialisms and regional terminology, other issues were specific to formal distinctions in cultural perspectives.

A number of employers felt that not having a shared cultural outlook with the older person could in some instances hinder the development of a strong caring relationship. This was also evident in the results of the

employer survey where respondents indicated that culture was a significant challenge to employing migrant carers (see Figure 6.6). Historical cultural references with respect to the social determinants of the contemporary fabric of our society and what it means to age within this society was also a factor. *“When you are talking about historical [understanding], [migrant carers] haven’t experienced...for example...the 1916 rising...whereas when I would go down the ward and if I meet an older person I could say to them ‘And what part of the country are you from?’ They haven’t that... cultural historical background of older Irish people... you get a cultural awareness, but do you have an understanding of the history? If I went to the Philippines tomorrow and if I was with a group of older people, would I understand the history of you know what it was like for them?”* Other employers highlighted the difficulties surrounding culture and race with respect to acceptance by older people in caring. *“Older people are afraid of coloured people, when they were younger they never saw coloured people.”* Although, employers did mention that when a care worker was from a common religious background (e.g. Catholicism), acceptance and shared context was not as much of an issue.

Cultural differences were also apparent in the approaches to older adult care. While registered nurses’ clinical ability was highly praised, their lack of social care experience was mentioned as being a barrier in caring for older people and in maintaining a person-centred approach to care. *“The bottom-line challenge is that the standard of care is maintained and with it the patient-centred approach to care. And 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.”* In particular, the ability of migrant nurses to grasp the softer-skill set, such as socialising and listening, was questioned.

To some extent, the difference in skill-set was thought to be a consequence of sourcing nurses directly from acute settings in countries that had a more family-oriented, community-based approach to older adult care. *“Most of the migrant workers that I have interviewed... the experience they have got, they don’t have the same system in their countries... Because their way of dealing with older people in their countries is completely different. It is not an institutional based care at all... the old people are cared for by their families at home and therefore that poses huge challenges for everybody.”* For others it related to levels of practical experience that carers have in dealing with people, as one survey respondent describes. *“They require vast amounts of support as they have no hands on skills when they arrive in Ireland. Degrees are no good if a patient requires two hourly turning and they have never done that.”*

In addition, cultural differences in specific aspects of caring for older adults were highlighted, the most prominent of which concerned palliative care and death and dying. *“Issues around death and dying...Depending on what country they come from, there can be issues around that...For example some nationalities don’t like to touch the body of a deceased person. So you don’t always have an undertaker to come and do everything immediately, so you have to touch and you have to take care of the person who has died.”* Similarly, *“It [the need for death and dying care] doesn’t impact on them at all. So our culture of dying and looking after the relatives as well as the patient...they do their job, they mind their patients and they turn them and they look after them, but it is a clinical job to them...they can’t grasp our culture of where we embrace the whole family and we understand it and a bit of a wake and all that- they don’t even want to know about it.”*

Nevertheless, the majority of employers and nurse managers praised migrant carers’ work ethic, their willingness to learn and their commitment to providing care to older people. A strong work ethic was a significant theme to emerge from the employer survey and the employer interviews. There was a distinct appreciation for migrant



carers and the level of dedication that they show in completing the necessary duties and responsibilities. These attributes were in contrast to employers experiences with some Irish workers. Migrant carers were seen by a number of interviewees as a more reliable workforce, who had very little sick leave and absenteeism and were willing to work full-time and shift hours. *“The main advantage is, 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.”*

Interviewees mentioned that many foreign national employees possessed a very strong caring ethos and value system, which helped to foster an understanding of the needs of older people and assisted in creating a stronger relationship with the care recipient. Aside from these values being complementary to the principles of care and compassion, there was an appreciation that they were compatible with the beliefs of older adults. *“Their culture and their belief and their value system, in a lot of cases would be similar to our own and Ireland in the past maybe. So there would be a nice link with the elderly people...We find in most cases a lot of them are very gentle; they are nice family orientated people.”* Advantages with respect to cultural diversity in approaches to care, potential for cultural learning, and sheer cultural novelty within the caring environment were also mentioned.

Responses to an open survey question supported these findings. Again work ethic was specifically mentioned, with education levels and approaches to care also emphasised. *“They [migrant carers] have a better work ethic, are more flexible, loyal (hungry for the work like the Irish were in the 50s). They are very gentle and caring to elderly people and most of all, they are better educated, trained and have the right experience.”* Another employer commented that *“Without them we could not run the service.”* Cultural benefits, with regard to both older adult well-being and other staff learning, were also noted. *“Migrant workers open up a whole new world for the older people and their colleagues.”* A number of employers, however, highlighted that it is not possible to generalise across all workers, especially on the basis of culture or nationality. *“I feel very strongly that the qualities/benefits brought to our nursing home by migrant workers varies from one person to another. It depends on the person not his/her country or origin, how he/she will perform in the workplace.”*

From the perspective of some migrant carers, cultural distinctions between attitudes towards older people in their home countries, and in Ireland, were also evident. This was particularly true for participants from African cultures. People spoke about an inherent respect within their societies not only for older people, but for the chronological age of others. *“In my place it’s not the same...If you see someone ...not even someone old, if you see somebody that is older than you... I am the one that’s supposed to greet...because you are my senior... I was using a bus...Whether the person is using a walking stick, or he or she is strong... and I know that this person is older, I will get up, I will offer the seat for him, because it’s the respect. But they don’t do it here.”* This respect for older people was for some underlined by a deeper spiritual belief that older adults had a closer connection with God. *“We look at our elderly people as...I mean after you think of God...I mean the spiritual...we look at them as you know close to that ...when I was young, we loved to do things for the elderly people, because we just want them to say ‘God bless you’, to pray for you, because we believed when they do that for you, it goes a long way...Unlike here...I don’t see the attitude of the people here to the elderly people...like you see an elderly person carrying heavy shops,you want to help them to take it, but here it’s not so.”*

That said, the majority of interviewees did not think that there was a substantial distinction between the respect given to older people in their home country and in Ireland. Instead perceived cultural differences surrounding attitudes towards older adults focused more on the structure of the health and social care systems and the role of the family within those systems. Reference was specifically made to the institutional models of care for older people in Ireland and the effective substitution of a nursing home for a person’s family as the

primary care provider. *“Because in our country, you have to mind your own elders... You have to keep them in your home and mind them because we do not have nursing homes.”* The absence of nursing homes, apart from those for the very ill, was echoed by all nationalities interviewed. The role of families as primary caregivers was for some linked to wealth and lack of government provision, but for the most part appeared to be related to cultural tradition and to a deep sense of responsibility to older people. *“Where I live, there isn’t a nursing home. And what we usually do is we care for our older people... I mean as they grow old, we usually keep them at home with us... and that’s your obligation, because it’s our culture.”* Similarly, a participant described the strong social expectation associated with families caring for older people in some cultures. *“Like you’re elderly, you’re family, you take care of them... If you don’t, the bad words from the community, the insults, the talking would put you straight really. You know because it’s like you don’t have your face in society, if you can’t take care of your elderly, it’s like a shame.”*

On the basis of this strong family involvement in care, some interviewees expressed dismay at the strong presence of institutional care in Ireland. Nonetheless, interviewees recognised the differences in social and economic contexts between Ireland and their home countries that influence the kind of care that can be provided. *“Well here in Ireland, nobody left at home, they are all busy and working, so they need to put the elderly, their grannies or their parents in the nursing home. That’s the difference and they can afford to pay anyways.”* In addition, other participants noted the benefits that are obtained from a more structured form of care provision within a long-stay facility. *“I could really say that it’s amazing and it’s difficult at the same time to leave your folks in the long-term facility. But it’s also good, because they’re getting the best care.”*

Several migrant care workers interviewed expressed concern for the state of the health and social care system in Ireland. Primarily, issues surrounding the waiting times to access services and the excessive cost of these services were mentioned. Concerns about the quality of the care being provided were also raised. This was particularly in regard to the prevalence of MRSA (*Methicillin-Resistant Staphylococcus Aureus*) and the apparent lack of hygiene in some care settings. For others, perception of the Irish health system appeared to be connected to the standard of health and social care in their home country. As a consequence, and by contrast to those who were dissatisfied with the state of the Irish health system, there was a relative appreciation among some migrant care workers for the care services in Ireland. This is evident in a female carer’s description of the health system in her home country. *“Nobody cares. Your money speaks for you. How well you’ll be taken care of... Nobody’s going to take care of you, you take care of yourself.”*

Older Adult Experiences with and Acceptance of Migrant Carers

The acceptance of migrant carers by older people is an important factor in ensuring an effective caring relationship and thus influences the quality and standard of care that is received. While in some cases acceptance is a function of socio-cultural, political and personal perspectives, it also relates to experience, and in this study the experience of older people with migrant carers. Given the importance of these factors in providing insight into the current context and in determining the future sustainability of the migrant care workforce in the sector, this section of the report explores older adult experiences and acceptance of migrant carers.

The majority of older participants spoke highly of the caring ethos and the nature of migrant care workers. Participants’ admiration was particularly strong for carers from the Philippines, which is likely to be a reflection of the more established relationship between Filipino carers and the Irish health and social care sector. In addition, and as with employers, the focus group participants stated that there were clear similarities between the value system of some migrant cultures and what was perceived to be our family centred approach to older



people in the past. There was a sense of regret that we as a nation have seemed to have lost this focus, with older people no longer being prioritised within the family unit and wider society. *"We in Ireland had... a better approach to older people 50 years ago than we have now... and I think with affluence we have become less caring... The richer you become, you can dump what appears to be a problem for someone else to look after."*

The nursing home residents were very positive in their descriptions about their experience with their migrant carers. *"They really are friendly and kind."* There was a distinct appreciation and fondness in participants' accounts of the caring relationship that they formed with their carers. In this manner, care delivery appeared to encompass more than service provision and nurtured feelings of attachment and friendship. *"I think they keep their eye open on you, as to what position you're in."* 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."* Although, the focus group participants did acknowledge that the nursing home administration played an important role in ensuring that the carers were committed to the residents and provided a suitable level of care. *"It all depends on who employs them... if they're good to them... that makes an awful difference."*

The nursing home residents also described the opportunity for cultural learning and stimulation when interacting with people from different nationalities, *"We find them kind of interesting... because they are kind of different and we want to find out about them."* Even when it was their first real interaction with foreign nationals, the participants did not feel overly anxious when migrant carers were first introduced. This lack of apprehension was credited to cross-cultural differences no longer being as significant a barrier as they once were. *"I think there is more understanding now, because the world is a very small place. Do you see, people go on holidays now all over the world really so they know the different cultures and they're able to understand."* Participants noted that the success of the caring relationship was dependent on the attitudes of both the carer and the older person. Without a reciprocal element embedded in the exchanges between older people and their carers, it was felt that any caring relationship would be undermined. *"On your own attitude towards your carers and the people that are in here, if you're friendly and kind to them, it makes a great difference."* Similarly, individuals described the relationship with their migrant carers as an exchange of sorts that benefits both parties. *"We're helping them and they're helping us, which I think is a very very good exchange."* Participants did, however, clearly specify that they had no will to adapt to *"foreign foods"*.

From the employers' perspective, for the most part older adults' acceptance of migrant workers was not viewed as a significant challenge - as indicated in the employer survey (see Figure 6.6). Some interviewees expressed surprise at the ease in which older adults adapted to being cared for by a person from another country. *"We have a resident here just inside the door and she is Church of Ireland; the first thing, the first night the Indian nurse came in she says 'You are very welcome to the Parish!' "*

When issues of acceptance did exist, problems with language and communication often underlined older people's reluctance. In other cases, interview participants described how some older people were initially apprehensive and may have at first favoured Irish staff. *"People of 80 and 90, would not have grown up in this kind of an era... that you'd have migrant workers in your organisation and I found that it's hard for the resident to accept them... but when they got used of the idea...they accepted them as a part of the staff, they came to like them and appreciate them."* One employer also noted that families may sometimes gravitate towards Irish staff members when looking for information, even if they are not their relative's carer.

A distinction across care settings was evident with respect to acceptance of migrant carers. Home care organisations spoke of significant challenges in placing foreign national carers with older clients (as mentioned in Chapter 7) and attempting to operate against stereotypes of traditional Irish carers. *"Everybody we speak to*

wants a middle-aged Irish woman as a home care worker...because [there is a perception that] she is going to be that perfect care giver." Problems with acceptance were sometimes suggested to be a reflection of concerns surrounding security and trust with respect to one's own home and the sensitivities of intimate personal care in an unsupervised environment. But, there was an acknowledgement that these issues did not altogether disappear even if the carer was Irish. *"The difference is you are going into somebody's home, so it's a different culture and we're dealing with elderly people... 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."* A home care employer did state that sometimes the level of acceptance of migrant carers may have more to do with perception, than the actual preferences of older individuals and in that manner unduly impacts on an employers decision to hire migrant carers *"Maybe it's our perceptions as well, do you know what I mean. I think it's a lot to do with our perceptions as Irish people as well about employing [migrant home carers]."*

Home care settings also introduced additional issues for both the nursing home residents and community dwelling older adults who participated in the focus group discussions. Recognising the likelihood that migrant workers would be delivering this care in the future, both sets of participants did not object to being cared for by a foreign national. *"The problem is... who is going to care for us in a system such as that... because of the availability of carers, [migrant] people would probably come more readily to take the posts than Irish."* However, participants did state that because of issues of trust and security and cultural connections with the home, there would be a preference for an Irish carer. *"Doesn't matter what the colour of the skin is, if the individual coming in hasn't some experience of the cultural synopses in our homes...mightn't be able to give the same quality of service... you know the like and dislikes... what are the norms."*

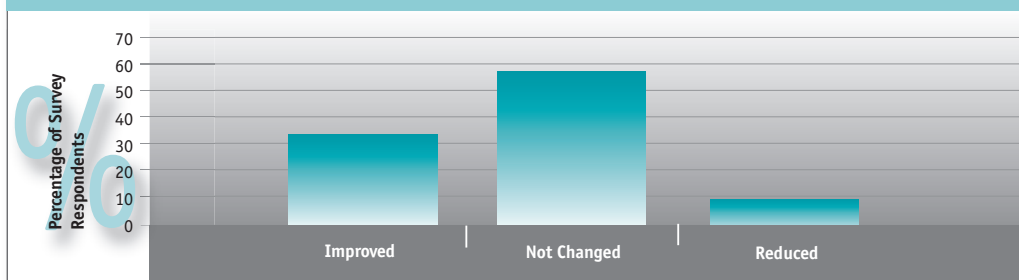
For many older participants, issues surrounding migrant carers working in the home care sector related to broader concerns about the current unstructured approach to delivery of care in private settings. Community focus group participants worried that this unregulated structure may lead to issues of maltreatment and neglect similar to those in some institutional settings whether care was being provided by migrant workers or native-born carers. Therefore, while there was an expectation that a better quality of life would be achieved by being cared for in one's own home, there was a recognition that abuses might be more difficult to identify and prevent in private dwellings. *"We all know what happens in nursing homes... is this going to be replicated now in our own homes?"*

Quality of Care

With reference to Figure 8.1, a third of employers surveyed said that employing migrant care workers has improved the quality of care provided by their organisations. However, the majority of respondents (58%) stated that the quality of care had not changed. Just 9% of employers said that employing migrant care workers has negatively impacted on the care delivered by their organisations. It is interesting to note that there is a significant positive correlation ($p < 0.01$) between the proportion of migrant carers working in an organisation and the reported impact on the quality of care delivered. This would suggest that the larger the number of migrant care workers employed in a facility the more likely the organisation will report that the quality of care has improved. In addition, from cross-tabulation statistics it appears that public long-stay facilities are more likely to report that the quality of care has been reduced than any other organisational type. As reported earlier, public facilities employ the lowest proportion of migrant carers out of all organisation types.



Figure 8.1 Reported impact of hiring migrant care workers on the quality of care



Source: Employer survey

In terms of the employer telephone interviews, the reported impact of migrant carers on the quality of care ranged from negative to very positive, but as with the survey, the majority of employers felt that the quality of care had not changed. This may reflect the fact that some employers specifically recruit registered nurses for care assistant positions, resulting in a higher skilled workforce. More generally, employers spoke about the education levels, professional training and clinical skill sets of migrant carers and the positive impact of such attributes on the quality of care. *“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, their work ethic you know...Like it’s simple things...like they have got skills like phlebotomy skills...they do IV...They are able to do clinical stuff in their own country. They would be likened to a CNS (clinical nursing specialist) here a lot of them. They have masters degrees. The people I am coming across are highly skilled.”*

Nonetheless, employers raised several issues about adaptation and other support structures for migrant carers. A number of people highlighted that migrant care workers understandably required additional time to adjust to the health and social care system and the Irish culture. The current absence of formal support mechanisms for migrant carers in Ireland only serves to intensify transition issues and increases 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 huge challenges and huge extra pressure on the Irish nurses.”*

Although the nurse adaptation programme provided by An Board Altranais was acknowledged, employers did not feel that this was adequate and questioned the role of An Board Altranais with respect to migrant nurses in the older adult health and social care sector. *“I think An Board Altranais needs to cop onto itself a bit and they need to firm up on communication skills. I know that they are there just to see that people are registered and that the registration stands up to scrutiny, but along with registration, communication skills are paramount and the IELTS [International English Language Testing System] at the moment are not good enough.”* The verification of qualifications, English proficiency assessment, and background checks were mentioned by several employers as areas that need further attention. A number of participants had created their own programmes for inducting migrant staff to compensate for this lack of official support. These programmes included additional orientation training to caring for older people and booklets of common phrases and colloquialisms.

Employer interviewees suggested that a more structured orientation to Irish culture, to the health and social care system and to particular age-related conditions (e.g. dementia) should be introduced. This would assist in

creating an understanding of the person-centred approaches in older adult health and social care and the linguistic and cultural aspects of Irish society. *“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 nuances, they need to know the colloquialisms you know.”* Conversely, one employer highlighted that there was a need for more cross-cultural education for all parties working in the older adult care sector.

As indicated in the results of the employer survey, the rate of turnover among migrant carers was not a major difficulty for employers (see Figure 6.6). While one employer expressed frustration that after training and orientation many carers (particularly nurses) would leave, most employers recognised that this was a natural process of progression for all carers, acknowledging that the older adult sector is sometimes used as a stepping stone to public and acute settings. *“To be fair, they have fulfilled their contract here and they move into the acute sector; they use the nursing homes to come into the acute sector...and they learn their culture here and they solidify their English Language skills and they get confidence...They don’t just walk off the job or anything.”* This pattern of intra sector transfer was also highlighted in the context of many nurses working as care assistants until their nurse registration is processed. However, a number of respondents described how some migrant carers become attached to older adult care and are reluctant to leave. *“We have one girl, her contract is nearly over and I said ‘Are you moving to the acute sector?’ and she said ‘Oh no, I want to stay here, I have learned so much and I like minding older people and I don’t want to go to the acute sector.’ ”* This was also evident in migrant carers’ reasons for staying in the sector as outlined in Chapter 7.

Specific nationalities were credited with being particularly caring, but other groups and ethnicities were said to have difficulty in dealing with older people. There appeared to be some inconsistency across the interviews as to the interaction of nationality and caring attributes – thus highlighting the difficulties in making generalisations. Therefore, it is more appropriate to note that employers were concerned at a broader level about why people decided to enter older adult care. A small number of employers felt that money was the principle motive for some migrant carers which sometimes compromised their approach to older people. *“Some of them [migrant carers] are excellent... and then you have more who are lacking motivation and are very concentrated on money and more hours.”* Others highlighted the role of training organisations as gateways to older adult care and queried whether all trainees were suited to the sector. FÁS was particularly mentioned in this regard.

Concerns in relation to the older adult care sector in general were also expressed. A suggestion to concentrate on care provision rather than the bureaucracy and documentation that surrounds the sector was made. This was with respect to immigration and employment regulations, but also to the amount of red tape involved in providing care for older people in Ireland. *“Now-a-days there is more paperwork which takes away from the caring.... And we need to get back to more hands on [care] and less paper work...the paper work seems to increase all the time”* A significant proportion of those interviewed would like 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.”*

It was felt that the importance currently placed on older adult care is not sufficient. There was a perception that considerable inequity exists in the current system of care. This was evident in the statement of one employer who highlights 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 eighty years and cost nothing; now that they're coming into long-term care they are seen to be a problem."

Finally, a number of employers stated that we should be less apprehensive about recruiting migrant carers, especially given that they are a growing labour force in the older adult health and social care sector. *"It is amazing... I sometimes wonder why people are reluctant to look at migrant carers, because I think they have a great lot to offer. They are highly skilled and well educated and I find their standards are quite good."* The suggestion was not just in terms of accepting foreign national carers as a component in our care system, but relates to being open to learning from the various approaches to care that they bring. *"I think it's great myself. For everybody concerned, for my residents, for myself, for my other staff... you have a great diversity of opinion you know, everybody has a great experience to bring to a place...It's what they bring, the people themselves."* There was an appreciation amongst employers that migrant carers are now a fundamental element of older adult care in Ireland, as one respondent to the survey commented, *"Without migrant workers - who would look after older persons in care?"*

As with the employers, older focus group participants also suggested that a cultural induction programme would benefit migrant workers in this sector, both in terms of labour market and social integration, and their caring approach. While efforts are required on the part of foreign nationals, the community-based focus group said that the state (the government and the citizens) 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...we are the state."* This referred to community and national projects and initiatives, and suitable policy. Appropriate information and evidence based infrastructure was also proposed to assist in dispelling many existing negative perceptions and barriers, particularly around asylum seekers and refugees.

The community-based participants demanded that a re-think of how we approach care for older people was necessary. It was felt that older adult health and social 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."* Participants also recognised that the issues surrounding migrant carers were 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 coming and their language skills."* In effect, the worth that we place on our older citizens was questioned. While the older participants found it difficult to say whether the impact of migrant carers on the quality of care was positive or negative, they did state that without foreign nationals it would be much worse, echoing the viewpoint of employers. *"Without these migrant workers, we wouldn't be able to staff a lot of the places... we're happy we have the care."*

Discussion



*"...the experiences of migrant care workers,
and the challenges that they face in caring for older people in Ireland,
must be framed within the context of the sector itself being marginalised."*

There are significant and complex issues surrounding the role of migrant health and social care workers in the Irish older adult care sector. This chapter draws on the findings presented in the previous chapters to explore the implications for the role, potential and sustainability of the migrant care workforce caring for older people in Ireland. The triangulation of data sources in this research indicates that many of the issues and problems identified in this report are common to all parties in the caring relationship, i.e. the employer, the caregiver and the care recipient. The central issues emerging from the data analysis extends across practice, regulation and policy domains. The following sections pay reference to each of these domains where appropriate.

Market for Migrant Care Workers

The number of migrant care workers in Ireland is influenced by both demand and supply factors. Growing numbers of older people in the country will continue to drive demand as disability increases with age. Income may also influence demand in the future as more older people and their families may be able to afford to pay for long-term care. The difficulty in hiring Irish carers and the perceived suitability of migrant carers also emerge as particularly strong determinants of demand in this research. In turn, the supply of migrant care workers depends on personal circumstances and economic conditions in sending countries, as well as on pathways to employment in the host country, in this case Ireland.

The difficulty in hiring and retaining Irish carers appears to be rooted in the general shortage of Irish care workers. There are potentially two interpretations of this view: (1) there are an insufficient number of paid Irish carers in the general health and social care system to meet the demands for care and (2) there are an insufficient number of paid Irish carers available to work in the older adult health and social care sector. Although it is likely that both situations contribute in some way to the deficit, the primary drivers of the shortage appear to be related to the second set of circumstances, that is, there are insufficient numbers of Irish care workers willing to work in older adult care.

Responses to the employer survey and the data from the employer interviews provide potential explanations as to why there is a shortage of Irish carers in the sector. Pay and conditions in the sector are perceived to be less than in other types of care; there is insufficient funding in the sector; career pathways are poor; and there is a lack of prestige associated with caring for older people generally. Researchers have noted that these problems are generally systemic of older adult care in other countries, so the difficulties highlighted in this study are not confined to Ireland (XU and Kwak 2005; Simonazzi, 2008).

Interestingly, Smith and Mackintosh (2007) highlight that the older adult care sector has long been disadvantaged with respect to the other areas of nursing and care provision. Through a historical analysis of divisions within nursing in the UK, (which was informed in part by the experiences of an earlier generation of migrant Irish nurses), the authors show that there was a 'pecking order' associated with different kinds of care institutions and medically defined specialities. Arising from the professionalisation of care in the 19th century, upper middle class women worked mainly in the acute illness sector, while working class people staffed poor law institutions and asylums for older people and the mentally and chronically ill. This distinction was reinforced through the association of 'high tech' care with acute settings and the association of '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 in older adult care and underlie the disadvantage of the sector.

The multiplicity of the problems within older adult care show the complexity of the challenge facing the sector.

The extent to which these issues are interrelated means that it is difficult to disentangle their significance and thus their influence over a carer's decision to enter or leave the older adult care sector. Nevertheless, it seems likely that they form the basis for some of the problems which have led to questions about the dependability of the Irish care workforce and the increased reliance on migrant care workers. Excessive sick-leave, absenteeism and turnover have been found to be related to inadequate employment conditions in the older adult care sector across a number of countries (Simonazzi, 2008).

Public sector long-stay facilities in Ireland find it easier to hire indigenous carers and thus have weaker demand for migrant carers. This strong indigenous supply is likely to be a function of two primary pull factors. The first is the standardised pay and conditions available to workers in public organisations and the second is the credibility or prestige associated with working in the public sector, which again can be related to the historic analysis of Smith and Mackintosh (2007). With respect to location of organisation, the increased difficulty in hiring Irish carers in strongly urbanised areas and strongly rural locations is likely to be based on different sets of parameters. In cities, the increased difficulty in hiring Irish carers is liable to be linked to the excess demand for carers in densely populated areas. Whereas by contrast, the difficulty in hiring Irish carers in rural countryside and village locations is more likely to be related to deficiencies in the supply of carers in those areas.

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. 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 are also likely to be increasingly influenced by the more subtle issues of poor career pathways, lack of prestige and the pull of other sectors. There needs to be recognition that many of the same issues that 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.

The appreciation of the work ethic of migrant care workers is particularly striking in the findings. Although, not having the same impact on demand as difficulty in hiring Irish carers, the associations between work ethic and foreign national carers appears to contribute substantially to the sustained demand for this workforce. Employers and older people alike noted that the willingness of migrant individuals to work and 'to get the job done' was admirable. For care organisations, having this focus and commitment to fulfilling duties and responsibilities was seen as a significant and beneficial attribute of any care employee. In this manner, the two drivers of demand (i.e. work ethic of migrant carers and difficulty hiring and retaining Irish carers) are connected. For many employers though, the admiration for work ethic among migrant care workers was independent of concerns or issues with Irish carers. As expressed by older people, there was a sense that migrant carers really wanted to contribute and succeed in their employment. Other researchers have documented similar findings in other countries, highlighting that employers often note the willingness of migrant workers to commit themselves to the job (Stiell and England, 1999) – even if these associations are sometimes culturally specific.

A note of caution is necessary here. In particular, the meaning that is attached to concepts such as 'work ethic' and 'willingness to work' needs to be considered and deconstructed. These terms were often used to refer to a host of positive work related qualities such as punctuality, lack of absenteeism, commitment to the job, fulfilment of duties and responsibilities and frequently, willingness to work all shifts. While some of these qualities are specific attributes of an individual carer, others have the potential to be influenced by the working environment. Therefore what may be perceived as a willingness to work could be a product of feelings of

obligation, pressure, lack of choice, or an individual thinking that they simply cannot say 'No'. Phillipson (2007) emphasised that issues such as these can arise in the older adult care sector because of the power advantages that an employer has in their relationship with migrant carers.

This is not to say that the appreciation for migrant carers' work ethic documented in this study is founded on unfair power exchanges - whether direct or indirect. The strength of the association between migrant carers and willingness to work is robust across care settings (i.e. institutional and home care) and organisation sector (i.e. public and private). Likewise, the literature in this area supports this finding on the 'hard working' nature of migrant carer workforces (Loveband, 2004; McGregor, 2007). What is necessary is an awareness that there are alternative meanings and associations and different perspectives encompassed within our perceptions of work and the work environment.

Economic Decline and the Care Worker Labour Market

The majority of this research was conducted prior to the recent severe downturn in the world economy. It is difficult, therefore, to estimate the impact of the current economic decline in Ireland on the older adult care sector. Although the demand for care is unlikely to waiver, and as evidenced by projections presented in this report is likely to increase in the medium to long-term, questions remain about who will be providing that care in the time of economic recession. With large increases in unemployment forecast for the Irish economy, increased numbers of Irish people may look to the older adult care sector for employment thereby reducing the need for migrant workers. Alternatively, with reduced opportunities for labour participation, family members may decide to care for their relatives themselves, reducing the need for paid carers, whatever their ethnic origins. If either of these scenarios occur, it is likely that existing migration policy will be altered to reflect the decrease in demand for migrant carers and to discourage foreign national care workers from entering Ireland. The growing unemployment in Ireland will also impact directly on the overall number of foreign national workers wanting to come here, thus limiting the pool of migrant carers available to work in the health and social care sector. Already, there is evidence to suggest that migrant workers as a workforce cohort are being affected by the economic decline more than Irish workers. By the end of the fourth quarter of 2008 the unemployment rate for foreign nationals was 9.5% compared to 7.3% for Irish nationals (CSO, 2009). Moreover the total number of immigrants into the State in the year to April 2008 fell by 26,000, and the number of overall emigrants out of the State has shown an increase, (CSO, 2008^b).

While a combination of these factors may arise, it is unlikely that they will be sufficient to completely undermine the role and potential of migrant care workers in the country. This is for a number of reasons. First, the number of people employed as registered nurses, nurses aides and care assistants in the general health and social care sector did not decrease during 2008. In fact, according to data from the Quarterly National Household Survey, there has been a growth of 7.1% in the number of people employed in this group of occupations compared to 2007. In addition, when comparing the fourth quarter of 2008 to that of the fourth quarter of 2007, health along with education are the only sectors to show an increase in the number of foreign nationals and Irish nationals employed (CSO, 2009). Second, explanations for the difficulty in employing Irish workers, discussed above, include such factors as lack of prestige associated with caring for older people. It is possible that even in times of economic decline such issues may prevent Irish workers, especially those who are highly-skilled, from entering the older adult care sector. This was apparent in one employer's description of the reluctance of Irish nursing graduates to enter older adult care even when faced with reduced job opportunities (see Chapter 6). Finally, for those Irish carers who do decide to enter older adult care it is likely that when employment opportunities arise again in the other health and social care sectors, a significant proportion will decide to return to these areas.



Language and Communication

Given the personal and intensive nature of the caring relationship, it is not surprising that difficulties surrounding language would emerge as a significant issue in this research. Proficiency in communication and understanding is fundamental to the delivery of person-centred care and directly influences the quality of care that can be obtained (Xu, 2008; Johnstone and Kanitsaki, 2008; Xu 2007^a; Brush et al., 2004; Tuohy, 2002). What is particularly interesting is that the findings illustrate the universality of these difficulties and their pervasive capacity to impact at a variety of different levels on migrant care workers caring for older people. Work practices, social connection and relationship domains are all affected by language and communication issues.

Language and communication difficulties can complicate the most basic and routine of work tasks. When caring directly for an older person these difficulties are accentuated because of the type of work and the characteristics of the parties involved. Articulating instructions and guidance for daily or rehabilitative activities and explaining the workings of a treatment become more problematic. Understanding the needs and desires of an older person, which is essential to the delivery of care, can be frustrated through difficulties in comprehending the expression of those needs and desires. These difficulties for migrant workers are further exacerbated by some of the communicative impairments that older people can possess. Sensory and perceptual impairments in hearing and problems in articulation are reasonably frequent among older people requiring care and can serve to compound the communicative process (Duff et al., 2002). However, it is not just with older people that work practices are complicated. Communicating with families of care recipients and participating in team work with other staff becomes more difficult when a person has poor language skills. These issues may compromise the level of effectiveness that can be achieved within the caring environment.

At a broader level, language and communication appear to impact on labour market and social integration. Threaded with those issues surrounding work practices, it is understandable how communication deficiencies can function as a barrier to integration in the Irish labour market. Job mobility, qualification recognition and a match between skill level and occupation are likely to be harder to secure, given difficulties in communication – whether these difficulties are assumed or actual. Research has shown that problems in this area adversely affect the labour market integration of migrant workers (Winkelmann and Winkelmann, 2002; Orsetta and Sébastien, 2006). O’Connell and McGinnity (2008) found that foreign nationals from non-English speaking countries suffer an occupational gap in the Irish labour market, whereas those from English speaking countries do not. The authors also found that English language skills are positively related to earnings. These findings support the work of Barrett and McCarthy (2007^a), which was outlined in Chapter 5.

In terms of social integration, issues around language and communication have been found to restrict foreign nationals from mixing outside of their own ethnic and cultural communities (Chiswick and Miller, 2002; Omeri and Atkins, 2006). Similar findings were evident in this research indicating that language could act as a barrier to workplace and wider social integration. For instance, employers noted that particular cultural groups tend to speak their native language in the company of other staff. Given that mixing with other staff is a significant channel for wider social integration, this pattern is liable to reduce the diversity and size of social networks among migrant carers. The development of relationships is closely related to social and workplace integration. Being able to converse with other staff members assists in the formation of a professional working environment and stronger social bond amongst employees.

Feelings of trust and safety, which are essential to maintaining the quality of care, are established through the development of the caring relationship with an older person. Problems surrounding language and

communication mean that any such relationship is that more difficult to nurture. The sense of connectedness, even on a professional or caring level, between two people is more tentative the more the communicative process is hindered. As noted by employers and older people in this research, communication and in particular conversation is especially important in the care of older people. The conversations that many older people engage in embody a wealth and intricateness of colloquialisms, historical context, cultural references, phrases and narrative, which together weave a dialogue that is rich and poetic in its meaning and description. Being able to engage in that dialogue enhances the caring experience for the older person and facilitates a stronger relationship with their care provider.

With respect to regulations and training for language and communication, there are few statutory or regulatory standards in place. As a condition of nurse registration for non-EU nurses, applicants are required to demonstrate proof of English language proficiency if English is not their first language. A set minimum score is required on the International English Language Testing System (IELTS) academic test or on the Test of English as a Foreign Language (TOEFL). Both assessments examine English language listening, reading, writing and speaking, (Irish Nursing Board, 2009^b). Applicants from inside the EU-25 region do not have to demonstrate English language proficiency, even though many are demonstrably weak in that language. In such cases it is up to the employer to ensure that the employee has sufficient language capabilities to complete the necessary duties. There is not an official or sector wide requirement for care assistants to possess a minimum level of English Language proficiency. While some larger organisations and public bodies may organise language classes and assessments, again it is up to the employer to ensure that a care assistant has adequate language capabilities to fulfil their duties.

Culture: Awareness, Care and Identity

The overlap between issues of communication and culture is considerable and reflects the strong interrelationship between aspects of contemporary culture, cultural heritage and the way we express ourselves and converse (Xu, 2008; Johnstone and Kanitsaki, 2008). However, as noted the significance of culture in this research goes beyond the connection with communication. The concern expressed by employers that poor knowledge of Irish culture results in a poorer understanding of older people, their experiences and their needs is particularly strong. Having a shared cultural outlook and a similar set of historical references fosters a stronger relationship with a care recipient. Research in this area, especially with respect to older adult care, is limited (Brush et al., 2004). Xu (2007)^b and Brush et al. (2004), however, do note that having an awareness of the cultural perspective of the person being cared for is crucial to maintaining culturally appropriate care and a person-centred focus in delivering care.

The relative homogeneity of the Irish older population means that cultural awareness in the context of the delivery of long-term care would concentrate on the Irish culture and particular aspects relevant to older adults (e.g. traditions and historical references). It is necessary here to distinguish between the context of an Irish caring environment and that of the wider Irish society. The need for cultural awareness emerging from this research is set amidst the role of the care provider and is specific to the nature of care itself, where a shared connection between the carer and care recipient is beneficial to the caring relationship. References to cultural awareness are isolated to this context, and are distinct from arguments made for the cultural assimilation of migrant populations into host country society.

There is also the deeper issue of awareness versus understanding, which was highlighted by one employer in the study. To an extent, awareness, in terms of being conscious of or having knowledge of, is reasonably straightforward to foster. Understanding is thought to be that more difficult to develop. In a care setting,



the understanding of a person's culture is about comprehending the cultural histories, traditions, ethos and ethics of the individual and how these factors inform contemporary cultural perspectives and values. In effect, cultural understanding is about the complexity of society and the multifaceted nature of the determinants that influence societal outlooks. In this manner, and as opposed to an awareness, it is more likely to be a function of time and the experiences and relationships that are developed in connection with a particular culture.

Xu (2007)^b states that the most challenging aspect of pre-arrival preparation and training for international carers concerns cultural values and beliefs. Failing to instil an understanding of such socio-cultural constructs impacts on the capacity of migrant carers to provide care that is culturally appropriate to the care recipients. In addition, there is a growing literature that carer-care recipient cultural incongruence may have an influence on the incidence and impact of adverse events for patients, and as a consequence care recipient safety could be compromised (Johnstone and Kanitsaki, 2008). As with language proficiency, problems in cultural understanding are accentuated due to the intimate and social nature of older adult care activity – not to mention the compromised capacities for communication. A sense of shared cultural and historical background provides a framework for the relationship with a carer that is essentially familiar and comfortable for the older person. In the absence of this mutual outlook, it is more difficult for the older recipient to orientate him or herself to the care dynamic, making the establishment of a connection with their carer problematic and hindering both clinical and social aspects of care delivery.

It is for this reason that a common or similar religious background is sometimes perceived to be beneficial for caring relationships to evolve successfully (Narayanasamy and Owens 2001). Due to the central and pervasive role that the Catholic religion played in Irish society up until recently, religious beliefs and values are particularly strong for the current generation of older adults. Employers who took part in this research did not acknowledge targeting specific groups of migrant carers for their religious or spiritual beliefs, but did recognise the potential benefits of shared religious experiences between caregivers and care recipients. The importance of religion and spirituality to older adult well-being has been extensively documented in the international literature (Koenig et al. 1998; Krause 2003; Kirby et al. 2004). Studies have shown that older people rely on their faith and spiritual belief system as a coping strategy to assist in adjusting to dependency, bereavement and end of life (Jenkins and Pargament, 1995; Fry, 2001; McClain et al. 2003). Thus, for an older person's carer to understand and to share a similar religious perspective strengthens the connections between the carer and care recipient. Interestingly, even for those carers and older adults who did not share the same religious background, religion could still foster acceptance through a mutual appreciation for each other's commitment to a set of religious principles.

The interaction between care delivery and culture was also evident in the approaches to care. The findings suggest that for many employers there is a distinction between the philosophies of care that underlie the Irish older adult health and social care sector and those that are exhibited by some migrant care workers. Research in this area has shown comparable differences across countries, highlighting the need for orientation to host country health and social care systems (Xu 2006; Xu 2007^b). Moving from a care system, which is based on a different socio-cultural and economic context, means that the same knowledge and understanding of procedures, policies and practices (e.g. person-centred care) will not be present when first working in a host country.

Interestingly, the employer survey and interviews indicate that, for the most part, employers are not concerned about the technical and clinical aspects of migrant nurses' skill set. In fact many employers praised the clinical expertise of foreign national registered nurses and recognised that even in comparison to Irish registered

nurses they possessed a technically advanced skill level. The social or softer skills of migrant carers were, however, sometimes an issue, particularly in relation to end of life care. Understandably, how a carer interacts with an older person must be appropriate in terms of tone of communication and physical touch. These aspects are fundamental determinants of the quality of care and ultimately can reaffirm or undermine the dignity of the care recipient (Woolhead et al. 2004).

The fact that the majority of non-EEA migrant nurses are sourced from acute settings, or training programmes specifically for acute care, appears to be certainly one of the sources of these issues. In addition to any differences inherent in the philosophies of source and host country care systems, there are distinct differences across acute and long term care settings. Acute care focuses more on medical interventions and places less emphasis on the social model. As a consequence, and as evidenced in this research, there appears to be a significant training challenge to orientate migrant registered nurses to long-term care settings and philosophies of care. These issues are not confined to migrant care workers of course and reflect a general dichotomy between acute and long-stay philosophies even for indigenous workers.

Considering that the majority of source countries are developing nations with little formal structures for the care of older people, it is not surprising that these issues exist. Dyer et al. (2008) found that migrant carers have particular difficulty in adjusting to a formalised system of care when informal approaches are used in their home country. While this adjustment relates to particular practice issues, such as training and orientation, it also refers to differences in attitudes and perceptions. Some migrant carers found it hard to adjust to the level of institutionalisation in older adult care in Ireland and to the diminished role of the family in caring for older relatives. Dyer et al. (2008) highlighted that for nurses trained in India and the Philippines there is an expectation that care for older people should be provided by family or relatives and not by a third party or the state. Again, this would suggest that differences in cultures of care with respect to source and host countries are significant and operate on a variety of different levels.

On the other hand, migrant carers coming from less developed and traditional economies may bring values that are more in line with those of older people in Ireland today, given our more family and community orientated society in the past. The traditional caring ethos shown by some migrant carers means that there may be a level of congruency between the older person's needs and desires and the particular attributes and qualities of the migrant care provider. Even though there is a distinction here between a congruent value system and common religious or spiritual background, there are also interconnections and interrelationships that must be acknowledged. Just as similar religious beliefs can serve to enhance the caring relationship so too can congruency of a set of moral beliefs and values.

In discussing associations with caring ethos and work ethic, there are inevitably questions surrounding assumed cultural characteristics and the role of cultural identities (those that are imposed by society) in informing our perceptions of migrant carers. It is important to acknowledge that pre-existing stereotypes, as well as prejudices, can serve to influence how we look upon cultural groupings – whether this is in a general societal context or specific to work occupations and settings. For instance, in an exploration of ethnicity and the care labour market, Loveband (2004) found that cultural stereotypes were in operation for particular migrant groups and may be influential in employer recruitment.

To this end, the impact of national and cultural associations is akin to the concept of the 'social nature of labour' - social division constructed outside the market that influences employment opportunities (Peck, 1989) - and labour market segmentation (Bauder, 2001). Cultural capital theory links the process of labour segmentation to



cultural identifiers or symbolic markers that are associated with behaviour, norms and material traits. These symbolic markers signify cultural identity that allows or denies workers the opportunity to manoeuvre within the particular context of labour market segments (Zukin, 1995; Fernández Kelly 1994; – as outlined in Bauder 2001). In the context of migrant carers working in the older adult health and social care sector, the symbolic markers would involve judgements on their capacity for caring and the set of attributes that would assist in facilitating that capacity.

Within this research, praise for caring ethos was especially strong for carers from the Philippines and India. This is not surprising as there has long been positive associations between Filipino workers and positive cultures of care in Ireland, with similar associations becoming increasingly evident for carers from India. Links between Eastern European migrant workers and the concept of a ‘hard worker’ was also evident in this study. While it must be said that there is no evidence to undermine such perceptions, perceived connections between cultures of care and particular nationalities were not consistent across all participants in this research. It is not possible within the scope of this report to deconstruct such associations and identify the role of cultural stereotypes in their production. However, it is acknowledged that existing stereotypes and cultural assumptions do influence our perceptions of migrant carers, both positively and negatively. As a consequence, we should be cautious in assigning any robust association at such a generalised level.

Discrimination in the Older Adult Care Sector

The findings of this research suggest that while discrimination is not widespread in the older adult health and social care sector, it does occur. Drawing on the accounts of all participant groups in this study, discrimination in the sector can be seen as a multifaceted construct that has a complex and interrelated set of underlying drivers, various perpetrators, and occurs within a range of different settings. Although both the settings and perpetrators are readily identifiable, the reasons for the discrimination are not as clear. To explore these underlying factors, it is helpful to consider the primary categories of discrimination and the principle determinants.

The explicit, and thus more severe, and the more subtle, and by contrast less severe, discrimination found in this research can be compared to Gaertner and Dovidio’s (1986) dichotomy of *blatant racism* (overt discrimination against minorities) and *aversive racism* (more complex and ambivalent racial attitudes). Taking the evidence of both migrant carers and their employers, workplace discrimination (whether explicit or more subtle) in the sector can be broadly categorised into: work favouritism, work segregation and care preferences.

In this context, work favouritism refers to behaviour exhibited primarily by higher level staff (e.g. employers and care managers) that overtly favours one set of employees over another. While in most cases favouritism involves Irish workers receiving preferential treatment to migrant workers, evidence presented in Chapter 7 indicates that some migrant groups are also favoured over other migrants – this was particularly evident for non-EEA carers who believed that Caucasian European workers received better treatment than they did. Favouritism can be manifested through selective work rostering, selective recruitment and promotion, and lack of attention given to migrant carers. Literature on discriminatory behaviour has documented favouritism as a major form of workplace discrimination (DiCicco-Bloom 2004; Kyriakides and Virdee 2003; Carlsson and Rooth 2007; Dodson and Zincavage 2007; Anderson and Rogaly 2005). For instance, a recent study by the Economic and Social Research Institute demonstrated that workers with Irish names were more than twice as likely to be invited to interview, than candidates with identifiably non-Irish names (McGinnity et al. 2009).

Work segregation describes the collection of discriminatory behaviours that contributed to isolating or excluding migrant carers within the working environment and arise from dealing with other employees and even some employers. Incidences include Irish staff not wanting to work with migrant carers, (whether explicitly stated or through avoidance behaviour), additional tasks left for migrant carers to complete on their own and Irish carers questioning or undermining the qualifications and experiences of foreign national workers. Although cultural, ethnic and racial characteristics and attributes are often the cues for this sort of behaviour, concerns about job security, job promotion and workplace performance may also contribute to workplace tensions (Omeri and Atkins 2002; Alexis et al. 2007; Larsen 2007).

Discriminatory behaviour surrounding care preferences arise from dealing with older people and their relatives and focuses on the stated preferences of older adults and/or their families for care delivered by an Irish carer. The explicitness of these preferences and how they are articulated determine the level of severity of this form of discrimination. Such preferences can sometimes be voiced very strongly, exhibiting both racial and xenophobic undertones. Similar patterns of abuse have been documented in the literature. Berdes and Eckert (2001) and Cuban (2008) highlight the objections of some older people to being cared for by foreign nationals on the basis of race and ethnicity. In other cases, especially those involving relatives of older people, preferences concentrate on the suitability of the migrant carers and focus on qualifications and the ability of the carer. Previous research has shown comparable mechanisms of discrimination in other countries (Alexis et al. 2007).

The interaction between immigration status and workplace discrimination was evident at a variety of levels within the research findings. Regardless of official categorisations the marginalising effect of migration is manifested through an absence of social and professional networks and lack of information concerning rights and entitlements and support organisations. As a consequence, some employers may use this lack of orientation as an opportunity to exploit migrant carers. Without knowledge of workplace standards and channels for reporting employment law violation, exploitative employers are more likely to avoid detection and prosecution.

In the same manner that lack of knowledge can enhance the vulnerability of migrant carers in the workplace, restriction on job mobility means that discriminatory behaviour is more likely to be endured. The requirement to stay with a specified employer for a fixed duration introduces a form of contract that is akin to 'bonded labour', placing the migrant carer at a considerable power disadvantage and increasing the potential for exploitation. There has been substantial research to indicate that this form of conditional permit increases the likelihood of workplace discrimination and exploitation (Piper 2004; Dyer et al. 2008). While there is a provision in the employment permit system that allows workers to move away from employers under abusive circumstances, the separation process can take a long time to complete and requires the carer to make an official complaint against their employer.

Problems in identifying and reporting incidences of discrimination may effectively encourage some employers to maltreat or exploit their care workers at little or no perceived risk to themselves or their organisation. This is particularly true in the case of live-in carers, where the labour inspectorate does not have the right to enter a private dwelling unless it is registered as a site of employment. Additionally, the dependency of migrant workers on employers for accommodation means they are considerably disadvantaged with respect to bargaining power and asserting their rights and entitlements. The descriptions of migrant carers show clearly that the initial periods of working in Ireland and in the older adult health and social care sector can compound many of these problems. Understandably, a carer's first job is likely to be characterised by a process of orientation and new experiences and consequently can potentially be a source of discrimination and exploitation in itself.

Race played a significant part in the discrimination suffered by some migrant carers and was perhaps the



strongest determinant of prejudicial treatment. In general those individuals who could be considered visible minorities appeared to be susceptible to greater levels of discrimination. The literature documenting abuse in the care sector describes racial prejudice as a significant problem for migrant carer workers of colour working in health care settings (Hagey et al. 2001; Berdes and Eckert 2001). The severity of the discrimination and abuse appears to be directly related to skin colour, with people of darker skin colour receiving the strongest forms of maltreatment. In the qualitative analysis of interviews with migrant carers, it was clear that carers from African countries were more likely to be susceptible to this sort of behaviour. Similar findings were documented by O'Connell and McGinnity (2008), who analysed the impact of ethnicity and nationality in the Irish labour market and found that black migrants are seven times more likely to report experiencing discrimination than Irish nationals while looking for work. In a qualitative study of migrant carers in the Irish long-term care system, Doyle and Timonen (2009) also found that African carers experienced the highest levels of prejudice and discrimination, when compared to South Asian and European carers.

Previous studies highlight the complexity of racial social constructions in contemporary societies and acknowledge the multidimensional structure of racism that is shaped by a variety of societal cues, concerns and distinct and explicit prejudices (Cortis 2003; Sommers and Norton 2006). An exploration of the factors that motivate racism is difficult to conduct within the scope of this research. Even so, discussions with migrant carers, employers and older people indicate that discrimination towards African migrants extend beyond issues of race to embrace elements of cultural stereotyping. Ethnic and social associations appear to be interwoven with perceived generic racial traits to produce a socially constructed perception of people of colour - particularly those individuals from African countries.

Given the relatively new phenomenon of inward migration in Ireland, the more prevalent factors that contribute to images of African people are likely to have become active in our recent history. Negative associations surrounding asylum seekers and refugees are evident in Irish society. Concern for abuse of the asylum system and, subsequently, the welfare state are prevalent. The subjective nature of the asylum process and the difficulty in verifying the authenticity of a '*well-founded fear of being persecuted*' (section 2 of the *Refugee Act 1996*) adds to questions around genuineness of refugee status. Together with perceived corruption in home countries and unsubstantiated media reports of organised crime involvement, concerns for system abuses seem to contribute to strongly negative perceptions of African migrants. Such associations may even be present for African migrants who have entered Ireland through other immigration channels (e.g. employment permits or student visas). This socially constructed stigma may help to explain the difference between the severity of discrimination suffered by African migrants and other visible minority groups, such as those from India and the Philippines who are primarily labour migrants from countries perceived to be less corrupt and, in some sense, thought to be '*more like us*'.

Gender has been shown to generate another layer of bias and discrimination for migrant workers (Piper, 2004). In the context of this research, and from the descriptions of migrant carers, gender did not appear to be a principal driver of discrimination in this research. It is likely that this is in part a consequence of the predominantly feminised structures of older adult care embedded in Ireland, which is evident across both the Irish and migrant carer workforces. However, again caution is necessary here. Smith and Mackintosh (2007) outlined how traditional charitable, service and care orientated sectors, such as care for older people, are often marginalised because of engrained associations with female social roles. Thus, many of the sector wide issues (e.g. poor resource allocation), may be an indirect consequence of gendered associations with care and the lack of prioritisation placed on such roles by society and government. In this manner gender may motivate discrimination, but at a sectoral level rather than an individual level.

So far each driver or potential determinant of discrimination has been discussed and dealt with separately. However, there is debate that discrimination may have a cumulative nature and the effect of multiple marginalising factors, or group memberships, could increase the susceptibility of a person to acts of prejudice. For instance, an intersection between race, class, gender and age has been suggested to enhance the potential for disadvantage (Johnson and Wolinsky 1994; Levin et al. 2002; Atchley and Barusch 2004). The migrant care workforce possesses several demographic and socio-cultural characteristics that may combine to increase disadvantage and discrimination.

The findings of the research show that the very nature of some sections of the older adult care recipient population can exacerbate workplace discrimination. Dementia (e.g. Alzheimer's disease) and other degenerative conditions may impact on the acceptance of migrant carers by older care users. The degree of familiarity, whether based on social, cultural or racial characteristics, can affect the tolerance of cognitively impaired care recipients for the staff that surround them, (Son et al. 2002; McCloskey 2004). There was an awareness amongst the migrant carers interviewed that such conditions can influence the attitudes of older care recipients and as a result there was a sense of resignation that such behaviour cannot be helped. Nevertheless dealing with such behaviour can be difficult at a practice level for the delivery of care and at an emotional level for the well-being of the migrant carer.

There was also an acceptance that some older adults were simply not used to dealing with people from other cultures. As a result the attitudes of older care recipients can be motivated by an apprehension with having to be cared for by a migrant carer. In other cases, it was assumed that older people may simply not understand that some of their behaviour towards migrant care workers was inappropriate. Colloquial expressions, ethnic terminology and labels, which may have been acceptable in a past culturally and ethnically homogenous Ireland, are no longer appropriate in contemporary society. In an investigation of racial abuse of carers in residential settings, Berdes and Eckert (2001) found comparable patterns of behaviour referring to this form of discrimination as *anachronistic racism*. It is important to recognise, however, that given the recent nature of inward migration in Ireland, it is likely that more than just some older people exhibit this sort of behaviour.

No matter what the form or the underlying drivers of discrimination, the implications for older adult care are considerable and inherently damaging to the sector. In this research, the findings indicate that the impact of discriminatory behaviour is evident at three levels. The first, and most evident from this study, is at the level of the individual, with discrimination negatively influencing well-being, job performance and career development among migrant care workers. The second level relates to the caring relationship between the care provider and the care recipient. The presence of discriminatory attitudes and behaviour in the relationship will fundamentally undermine the quality of care that can be delivered. Thirdly, organisational efficiency is compromised. Discrimination within a workplace fosters low staff morale and increased turnover among migrant carers.

Given the ongoing potential for racism and discrimination, it seems counter intuitive that the *National Consultative Committee on Racism and Interculturalism* would be closed in 2008. While not directly concerned with migrant worker rights and entitlements, the organisation did by its nature help to identify and address issues of discrimination and racism against migrant communities in Ireland. For that reason, there are concerns about the ongoing protection of migrant workers in the Irish labour market in the future.



Integrative Process and Potential

There is evidence in this study of an initial apprehension of foreign national carers on the part of older people. While factors such as cultural and racial characteristics can impact on acceptance, initial apprehension seems to be primarily a product of lack of experience and poor knowledge of foreign nationals. Therefore, just as the relative absence of a racially and ethnically diverse population in Ireland can form the basis for some discriminatory behaviour and attitudes, so too can it contribute to an apprehension when first dealing with migrant carers. This hesitation is somewhat comprehensible given the lack of experience of the majority of Irish older adults with people of different ethnic and racial groups. When considered in the context of personal care and the comfort that cultural familiarity with care providers can provide, initial apprehension in a relationship with a migrant carer is even more understandable.

At the level of wider society, there are questions around whether our inexperience as a nation of migrant populations would pose a barrier to successfully managing a multicultural population. Such questions are particularly important when considering that migrant workers in Ireland do not appear to have become integrated into our labour markets (Barrett and Duffy 2007; Gonzalez-Perez et al. 2005). Goździak and Bump (2008), in a study of immigrant populations in new US settlement areas, stated that there were many common obstacles to social, economic and civic integration. Perceptions of short-term residency, concerns for enhanced competition in local job markets and exclusion of migrant populations from conceptions of community are just some of the barriers that were identified. It is fair to say that similar obstacles have been prevalent in Ireland over the past 18 years since the first recent inward migration was recorded. As noted in Chapter 4, although the Office of the Minister for Integration has been established, an integration policy has not been fully implemented to tackle these issues. Despite the fact that there have been efforts within the HSE to facilitate staff intercultural integration (e.g. staff intercultural induction), the absence of a national strategy is likely to have implications for the older adult care sector with respect to integration and acceptance.

That said, the new found multiculturalism in older adult care appears to have certain benefits – even aside from perceptions of work ethic and caring ethos. The novelty of the changing cultural demographic structure helps to explain the interest from both migrant carers and older care recipients in cultural learning. Thus, even though cultural novelty can serve as a basis for anxiety when dealing with migrant carers, it can also provide a channel for building a stronger relationship. The personal and intimate nature of care for older people creates a particular set of opportunities and dynamics where the care user and care provider are heavily invested (emotionally and physically) in the social and caring exchanges (Dodson and Zinavage 2007). This separates the care delivery process from the orthodox conceptualisation of a service and transforms the interaction into more of a two-way process yielding mutual benefits. From the findings presented in this research, there is evidence to suggest that the outcomes of the caring relationship can impact positively on both the older person and the migrant carer. Reciprocity appears to be a significant characteristic of the caring relationship. These qualities embedded within older adult care may help foster an acceptance of migrant carers over time.

The sense of shared migratory experiences among older people with migrant carers is particularly interesting. Although community participants expressed doubt whether experiences of emigration help older people to be more accepting of migrant workers, the nursing home residents indicated that it was a significant factor in shaping their attitudes. The duality of the migratory experience has been referenced in policy documents, advocacy reports and published research, but a detailed exploration of these shared experiences has not been undertaken. The evidence from this research study would suggest that, at the very least, there are parallels between the emigration patterns of migrant care workers and older Irish people. This occurs at two

generational points in relation to Irish emigration. The first is with respect to peer and personal experiences of emigration during young adulthood – typically during the 1950s, while the second relates to the more contemporary emigration of participants’ children and grandchildren in the 1980s and in the past 20 years for casual labour and travel. The likelihood is that for some older people a sense of shared migration experience will impact on their acceptance of migrant care workers. The extent that such experience will influence their outlook is likely to be a function of their knowledge of, and participation in, migration at both of these generational points.

Legislation for Care Preferences

Preferences articulated in an abusive or racist form are clearly discriminatory, and simply unacceptable in any working environment. However, there is a greater degree of ambiguity when preferences relate to fundamental components of person-centred care, such as communication and cultural understanding, and are not motivated by cultural or racial separatism. Arguments of autonomy of choice and concerns for the sensitivities of personal care then come into frame. On the other hand, allowing employment to be based on a set of criteria, such as these, is controversial, difficult to legislate for and potentially problematic under a human rights framework. As a consequence, and because of the implications of ignoring one argument over another, a discussion around these issues and whether such preferences are acceptable under any circumstances needs to take place.

The credibility of this debate lies rooted in the characteristics that are appropriate as a set of preferences for care. Already in some jurisdictions, employment law offers a degree of precedent. Under UK legislation for instance, employers are permitted to employ someone of a particular race, ethnic group, national origin, religion or belief if it is deemed to be ‘a genuine and determining requirement’ of a particular job. This is known as a Genuine Occupational Requirement (GOR) and may also apply to hiring someone on the basis of gender. The requirement must be shown to be a skill that cannot be easily learnt. (Department of Trade and Industry, 2003). With the importance of communication strongly evident in this research, it is understandable why language proficiency might serve as a criterion for employment. Of course, this is already the case in Ireland with language proficiency accepted as grounds for hiring a care provider. It is more complex when considering the implications of employment on the basis of cultural understanding given its subjective nature; its close connection with ethnicity and nationality and the fact that older people are typically of the ethnic majority in Ireland.

The danger is that these preferences will act as overt mechanisms for underlying discriminatory behaviour during the employment process and at a wider level in labour market integration. To a degree this may already be evident in the sector, as illustrated by the interrogation of migrant carers’ qualifications by employers, staff and family members. The difficulty arises when there is a threat of blanket assumptions about the level of language proficiency and cultural understanding among particular ethnic populations. Allowing such mechanisms provide structured channels for discriminatory behaviour.

Consequently, if we are to truly engage in considering the care preferences and needs of older adults there must be a corresponding effort to ensure that legitimate criteria for employment are not used as a shroud for discrimination and apply equally to the indigenous workforce. Aside from specifying the need to evaluate the qualities and characteristics of a carer on a case by case basis (and not on cultural and national stereotypes), achieving a comprehensive resolution to this very fundamental debate is outside the scope of this research study. An extensive process of consultation with all stakeholder parties would be necessary before such a resolution could be obtained. Nonetheless, it is helpful for the future quality of older adult care delivery that this issue is highlighted for immediate consideration.

Employment and Immigration Regulations

The vulnerability of foreign national workers to exploitation in the older adult care sector, is exacerbated by the existing regulations governing the employment of migrant care workers. In itself, this is a problematic aspect of the interchange between Irish immigration and employment policy that requires consideration. Problems with employer specific labour contracts and delays in processing permit renewals indicate a need for reform of such policies to prevent and address carer exploitation.

However, the vulnerability that is fostered by immigration and employment regulations is not just in terms of exploitation. The restrictiveness and bureaucracy of current Irish policy means that migrant care workers are vulnerable to reduced labour market mobility, compromised labour market integration (also highlighted by Gonzalez-Perez et al. 2005), reduced opportunities for employment and career advancement and, to a lesser extent, becoming undocumented within the care sector¹⁷. These outcomes are consequences of policies such as targeted employment of EEA nationals, quota restrictions on the number of non-EEA nationals in an organisation, labour market needs test, fixed-employer contracts and the length of time required to process permit applications and renewals. The findings of this research demonstrate the feelings of frustration and powerlessness that many migrant carers experience when dealing with government regulations. There is a sense that the immigration and employment system appears to be working against migrant carers, as opposed to facilitating and regulating employment in the sector. It goes without saying that some of these issues are likely to be common across all sectors of employment for labour migrants. With similar migration and employment channels in many countries, comparable difficulties have been identified to affect foreign national workers in other host nations (Piper, 2004; Rhus and Anderson, 2006; Dyer et al. 2008).

Many of the same regulatory policies and procedures that impact on migrant care workers also affect employers. From a care organisation perspective, some of these regulations translate directly into compromised efficiency, effectiveness and quality of care in older adult care delivery. Problems with delays in processing applications, time consuming paperwork and uncertain application criteria are indicative of employer concerns about the bureaucratic nature of government regulations for hiring migrant carers. The administrative burden involved appears to act as an 'obstacle course' that many employers find difficult to negotiate. Regulations requiring them to favour the employment of EEA nationals and place limits on the number of non-EEA employees were questioned by many employers. On the basis of these issues, it would seem that from the employer perspective there are legitimate questions surrounding the effectiveness of government regulations for hiring migrant carers.

The existence of a two-tier system of migration in Ireland introduces its own set of problems. The structures of the employment permit channels are designed to favour high skilled well qualified workers. Even though non-EEA registered nurses primarily enter on a green card, the existing restrictions mean that non-EEA care assistants are often found to be ineligible applicants. The care assistant occupation is not considered to be in short supply, nor does it pay in excess of €60,000 per annum and thus does not fulfil the criteria for a green card. It might be expected that non-EEA care assistants could enter through the work permit channel (which targets lower-skilled workers), but in practice since reform of the system under the *Employment Permits Act 2006* this appears to be rarely the case. The care assistant salary typically falls under the required remuneration level (in this case €30,000 per annum) and the 'exceptional circumstances' criterion seems to be seldom applied. Even for those individuals who are successful under the work permit scheme, the inequity of entitlement when compared to the green card programme is striking. Immediate family reunification, length of permit duration and a more direct path (at least intended to be) to long-term residency are all added

■ ¹⁷ Although efforts were made to include undocumented workers caring for older people in this research, it was not possible to identify or recruit these individuals. Data on undocumented workers in this sector is primarily anecdotal, with little certainty about actual numbers.

benefits of entering the Irish labour market on a green card compared to the work permit scheme.

While this two-tier system is representative of the migration model used by many countries in the developed world, it may not always be appropriate for meeting care needs within the health and social care system. In Ireland, the growth in opportunities for high skilled employment, the increased labour participation of women and the decline in religious and faith based organisations has meant an increased demand for migrant care assistants (as previously mentioned in Chapter 4). Although, there is an expectation that the EEA labour market is sufficient to meet this demand (even with an uncertain economic climate), there needs to be a reassessment of our conceptualisation of personal care before determining what or who it is we require.

In low-skilled occupations there is an assumption that essentially anybody can do the job. This is not true for personal care delivery. In part this is illustrated in the preferences of older people for qualities such as kindness and compassion, alongside clinical or professional training. The intimate and sensitive nature of care work and the requirement for personal investment in the caring relationship also removes care giving from the traditional construction of low-skilled employment. In using this conception of a care assistant, demand would no longer be driven by the extent of a labour supply within the EEA, but by the capacity and qualities of that labour supply to provide care for older people. Thus, it may be inappropriate to base entry to the Irish care workforce solely on skill, as dictated purely by professional qualification, and remuneration level. This would suggest that it is necessary to re-examine the channels of entry for care assistants working in the older adult care sector.

The findings of this research demonstrate that uncertainty around long-term residency and family reunification are significant issues for migrant care workers. Decisions to continue to work and live in Ireland, and ultimately to make Ireland home, are dependent on successful family reunification and clarity around a pathway to long-term and permanent residency. In a study exploring the intentions of migrant nurses in Ireland, Humphries et al. (2008) found that uncertainty around these issues can put future participation in the Irish care force in doubt and lead to plans for migration to another country. Both of these issues also appeared to negatively influence integration. Although the majority of participants in this study intended to still be living in Ireland in 5 years, a number of individuals expressed doubt as to whether they would ever feel at home here when it was not clear if Irish society was willing to accept them and their families.

Previous research on family reunification has shown that splintered family groupings can have a significant impact on migrant workers' well-being and sense of belonging in a host country (Asis et al. 2004). Broken family connections serve to accentuate already fragmented links with home nations and perceptions of disjointed cultural identities. Difficulties with family reunification for the participants in this study concentrated on two issues. The first is with regard to the length of time it takes to obtain permission to bring family members into Ireland. While for those individuals on green cards, this is less of an issue because of immediate entitlement, for those on work permits the one year waiting period is a substantial duration and often is an underestimation of the time needed. The second issue relates to the definition of family dependents and in particular the age limit that is placed on children who are eligible for family reunification.

Current migration channels in Ireland do not provide for permanent residency. As outlined in Chapter 4, there is a provision for long-term residency. However, the existing pathway to obtaining long-term residence appears to be a long (processing time approximately 18 months) and complicated process that can include an interim arrangement of a stamp 4 (permission to work in Ireland without an employment permit) until the Immigration, Residence and Protection Bill is implemented, (Irish Naturalisation and Immigration and Service, 2009^b). With the majority of non-EEA migrants resident in the state on terms and conditions that are usually temporary, conditional and discretionary, there is not only uncertainty with regards to long-term status, but there are also



implications for job security, job tenure and job mobility. Short-term permit arrangements, such as two year permit durations can also, in effect, undermine the continuity of care and the caring relationship and increase the required investment in technical and experiential training for the employer.

Whether or not Ireland abandons the market-led system and follows the UK's lead in introducing a points-based system, there needs to be an examination of the current immigration and employment regulations for hiring migrant care workers. The issues identified in this research limit the effectiveness of migrant care workers within the older adult care sector and influence negatively their decision to continue working in the sector. The absence of a coherent integration policy is, therefore, damaging the sustainability of the migrant care workforce in the state. Given that Ireland is competing in a globalised care market for health and social care workers, and is likely to have a substantial need for these workers into the future, reforming the current system and addressing these issues is very important.

Older Adult Care: Regulation and Inspection

As highlighted by the older adult focus group participants, the susceptibility of older people to abuse and victimisation in care is a concern. Employers and migrant carers echoed this unease at different points during the research and 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 issue illustrates once again that there are two vulnerable groups of people, who can both be potentially marginalised, at the centre of this research. The regulations that govern the care of older people, however, have attracted questions with regards to effectiveness, implementation and universality.

As outlined in Chapter 3, the new 'National Quality Standards for Residential Care Settings for Older People in Ireland' are an important watershed in the regulatory process for the care of older people in Ireland. The previous regulatory system in operation in the older adult health and social care sector was not adequate and in any case was confined to private sector provision. There needs to be careful monitoring to ensure that the new standards and inspection system are successful in protecting older people in residential settings. To a certain degree, the new standards established for care of older people will also offer some protection to migrant care employees working in the older adult care sector – at least in residential care settings. What this research has shown is that in addition to the need for significant investment and training for all carers, there should be a focus on the particular characteristics of migrant carers to ensure that not only they can deliver high quality care but that they are also supported and protected within the new regulatory environment

In the case of care delivered in a person's own home, the continued absence of regulation is a problem. Older participants in this research felt very strongly that even though living at home maybe the ideal, the potential for abuse could be even more considerable than in institutional settings. Employers in the home care sector also called for the introduction of standards to regulate the Irish home care market and to assure high quality care provision. Without appropriate legislative systems in place, the private and closed environment of home care could lose the homely and trusting characteristics that older people value so highly. Similarly, migrant carers working in private homes need to be protected and supported so that they can deliver high quality person-centred care.

Valuing and Prioritising Older Adult Care

Discussing the central issues surrounding migrant health and social care workers in ageing societies inevitably leads to deeper questions concerning the state of the older adult care sector in Ireland. All participating groups in this research (e.g. migrant care workers, older people and employers) 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 this research, there is a consensus of unease with respect to care provision for older people.

In this manner, poor pay and conditions, under funding of the sector, poor career pathways, lack of prestige and deficient regulatory structures are symptomatic of a collective failure to prioritise older adult care appropriately. Similar conclusions have been found in previous research that has examined the condition of older adult care in Ireland and in other countries (NESF 2005; Phillipson 2007). Ireland spends less on older people than most other European countries. 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 society in Ireland.

Although there has been substantial rhetoric regarding the need for person-centred principles of care and the rights and entitlements of older people, there does not appear to be a definitive effort to apply this discourse to health and social care policy (in terms of legislative support) and practice. Commentators have noted generally that the age-related policy that has been developed in the area of health and social services has been embedded with a distinctly ageist outlook – emphasising a homogenously dependent population and a reactive rather than preventative focus (NESC, 2005). More worryingly, 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 invest in and value the structures and personnel who provide that care, effectively challenges our attitudes towards our older citizens.

If the older adult health and social care sector in Ireland is marginalised then, being employed in a disadvantaged sector intensifies the marginalisation of an individual employee. Therefore, the experiences of migrant care workers, and the challenges that they face in caring for older people in Ireland, must be framed within the context of the sector itself being marginalised. While this is not to suggest that discriminatory behaviour is a necessary by-product of an under funded sector, problems are likely to be exacerbated by the lack of resources and support structures within the sector to address the various challenges faced by migrant workers.

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. In the previous sections, the natural overlap between standards, policy and legislation related to older adult care and migrant workers was noted; as was the absence of an inter-sector, inter-agency and inter-departmental approach to their development. To an extent, this may simply be a reflection that, apart from some cursory references in policy and guideline documents (e.g. National Intercultural Health Strategy 2007-2012 – HSE and Cultural Diversity in the Irish Health Care Sector – NCCRI/IHSMI 2002), this topic has received little or no public or political attention in Ireland. For the issues and challenges highlighted in this report to be addressed, a collaborative strategy is required involving the statutory, voluntary and private stakeholders who represent the intersection between older adult care and migrant workers. The development of a new National Strategy for Older People must explicitly reference and integrate the needs of migrant carers with those of older people.

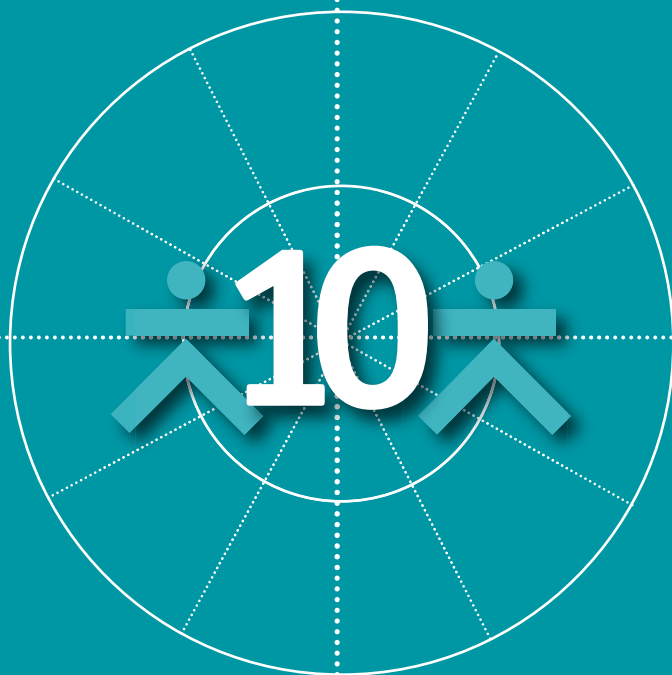
Valuing Migrant Carers

An important part of our research was to examine the value placed on migrant care workers by the various constituent parts of the health and social care system. A crucial question in this regard is whether or not migrant carers are simply used to fill job vacancies that Irish workers are not willing to take-up? For some employers who took part in this research, this is certainly the case. Given the opportunity and a more vibrant indigenous labour market some employers would hire Irish nurses and care assistants over their foreign counterparts. Challenges, such as language and communication difficulties, cultural understanding and requirements for extra job training are likely to be the primary reasons given for the preference.

For the majority of employers, it is not so straightforward. There is sufficient evidence in this report to suggest that while the initial motivating factor is typically to fill vacancies, sustained demand for migrant care workers demonstrates that the vast majority of employers and older people recognise and value their contribution to the sector. Appreciation and admiration for migrant carers' work ethic, caring ethos and diversity in approaches to care was evident amongst the employer and older adult participants in this research. This admiration is likely to be sustained even through the prolonged period of economic decline that we are about to experience. Therefore, there needs to be a stronger recognition at a national and sector-wide level of the contribution that migrant carers are making and will continue to make to our health and social care sector. Similarly, we need to understand that this contribution is not just wrapped up in aspects of organisational efficiency, but in fact directly influences the quality of life of older people in Ireland.

Acknowledging the contribution of migrant carers is important when discussing current and future need for care staff. There is a danger that we could become focused simply on the number of care workers that are required. As this research has demonstrated, the provision of care to older people cannot be conceptualised in the same manner as other service sector industries. The intimacy and sensitivities of the circumstances surrounding the caring relationship mean that service providers and service recipients (older people and their families) are heavily implicated in the service exchange. Consequently, while maintaining and enhancing the numeric capacity of the older adult care labour force is important, it is essential that we also focus on building quality provision that is based on person-centred care. Attracting migrant employees will serve to bolster the existing expertise and attributes of Irish care staff, and with investment in education and training for all care staff will create a caring environment that enhances quality of life for older people.

Conclusions and Recommendations



*“It is impossible to separate the fate
of migrant care workers from that of older people...”*

This study was primarily focused on the role and potential of migrant care workers in the care of older people in Ireland. There has been a significant increase in the number of migrant nurses and care assistants in the older adult health and social care sector in recent years. While most of the growth in numbers has been in residential care facilities, a significant number of migrant carers are now looking after older people living in their own homes. The recent downturn in the Irish economy has created a juncture with respect to the role of migrant care workers in Ireland. The economic decline is likely to negatively influence both the demand and supply of foreign national carers, particularly in the short-run. However, it is also likely that migrant workers will continue to be a feature of the care of older people for years to come in Ireland. For that reason this report is both necessary and timely to inform policy and practice beyond this point in time.

The conclusions and recommendations that follow are not only focused on migrant care workers, but also extend to policies and practice that impact on older people directly. It is impossible, as evident throughout this report, to separate the fate of migrant care workers from that of older people and their families.

Demand and Supply

- The projected need for migrant care workers into the future is likely to be significant. It is, however, difficult to estimate the impact of the current economic decline on this sector. Potentially, a return of Irish workers to the older adult care sector, increased involvement of family carers and a reduced number of foreign national workers entering Ireland could impact negatively on the numbers of migrant workers caring for our older people. However, it is unlikely that these factors will be sufficient to reverse the trend of increased reliance on migrant care workers in the health and social care system. Many of the factors that impact on demand and supply are independent of the state of the economy at any particular time.
- The strongest determinant of the demand for foreign national care workers is the difficulty in hiring and retaining Irish paid carers, especially in relation to registered nurses. These difficulties include negative perceptions of caring for older people, lack of career pathways and general under funding in the sector. Other reasons given for the difficulty in hiring Irish carers include their reluctance to work shift hours and, according to employers, their overall lack of commitment to the sector.
- Willingness to work flexible hours, strong work ethic and commitment to caring for older people were positive factors associated with the decision to hire migrant carers.
- The majority of older people in Ireland prefer to be cared for by their families in their own homes and in their own communities. Where this is not possible, people would still prefer to be cared for at home by someone who is reliable, kind and compassionate. Amongst older people, there was an acknowledgement that the sensitivities of one's own home, and the necessity for socio-cultural understanding within the home environment would lead to a preference for an Irish carer, but not at all costs.
- Migrant care workers make up almost a third of all health and social carers in the organisations surveyed with 87% of respondents employing some foreign national carers.
- Migrant carers were represented in all organisation types (e.g. home care organisations and public long-stay facilities), with the largest proportion in private rather than public organisations. The multi-cultural workforce was not specific to a particular geographical region, nor confined to urban areas, nor was it a function of population density.

- In order of importance, the primary source countries for registered nurses are India, the Philippines and Poland.
- The primary source countries for care assistants are Poland, the Philippines and Nigeria.
- The primary reason for entering older adult care is linked to opportunities for employment rather than being vocational. Yet, for some individuals, continued interest in remaining in the sector was linked to an attachment to the type of work and caring for older people.
- Informal networks featured strongly with respect to migrant carers entering the older adult care sector. While this was especially evident for care assistant positions, informal networks also existed for registered nurses. Informal networks were used by employees as pathways to employment and by employers as recruitment channels.
- Four out of ten employers used recruitment agencies to employ migrant care workers. The use of recruitment agencies was primarily skill driven, focusing predominantly on the recruitment of nurses from abroad. Dealing with paperwork was considered to be the primary advantage of recruitment agencies. Lack of support, the quality of recruited staff and dual fees for employers and migrant carers emerged as some of the major issues surrounding recruitment agencies.

Migrant Workers as Carers

- The caring relationship between migrant carers and older people is complex and multifaceted. But this complexity is not unique to migrant carers. Inherent within the nature of caregiving are a set of emotional and physical demands on the carer that feature as challenging aspects of caring for older adults and include: demands on personal strength, dealing with loss and with degenerative and debilitating conditions.
- The majority of migrant carers felt that the current rates of pay were poor and contributed to low morale, higher rates of turnover and ultimately poorer quality of care. These issues were, however, not confined to migrant carers; low pay was perceived by migrant care workers as a problem in the sector generally. While the rates of pay appeared to be generally better in the public sector, public-based carers also felt that the pay was not commensurate with the work expected or delivered.
- Although not a general feature of the majority of migrant carers' experiences, discrimination was and continues to be a significant issue for some individuals. Discrimination in the older adult care sector has multiple forms, multiple perpetrators and a complex set of drivers. Forms of discrimination can be broadly categorised as: work favouritism (e.g. selective rostering and selective recruitment), work segregation (e.g. staff avoidance and work left to migrant carers) and care preferences (e.g. preference shown towards Irish carer by older people).
- The drivers of discrimination included those factors that contributed to the construction of exploitative or discriminatory conditions (e.g. employment and immigration regulations, lack of information – particularly in the first job, and live-in care settings) and issues around race and socially constructed cultural identity. The more severe incidences of discrimination were typically experienced by people who were of darker skin colour and came from African countries. Refugees and asylum seekers appeared to be particularly susceptible to racial discrimination because of the perceived subjectivity in the asylum process, lack of information, rumours about system abuses and negative media coverage.
- While older people's preferences for Irish care providers have to be respected when articulated, there is the

danger that revealed preferences can sometimes be used as a cover for discrimination. The needs of older people with respect to language, communication and culture certainly have to be considered, but it is necessary to ensure that migrant carers are not discriminated against as a consequence.

- There is evidence to suggest that issues surrounding acceptance of migrant carers by older people and staff are concentrated in the initial period of commencing work. This period is often characterised by an initial apprehension that diminishes over time with increased work experience and the establishment of trust between migrant carers and care recipients and other staff.
- There was general concern about the lack of regulation of home care delivery in Ireland. Migrant carers recognised the potential difficulties with respect to working in private home settings - particularly if the carer was directly employed by the family to provide a live-in service. The potential of abuse of older care recipients to go unidentified in people's own homes was also recognised by respondents.
- Care for older people extends beyond simple service provision and is a reflection of the intensity and sensitivities wrapped up in the caring relationship. Feelings of making a difference, emotional attachment, friendship and personal growth were all positive aspects of the caring relationship for migrant carers. This reflected the strong theme of reciprocity which was embedded in the accounts of caring for older adults.

Older People and Migrant Carers: Perceptions and Experiences

- Language and communication was perhaps the most significant challenge identified by migrant carers, employers and older people. Migrant carers spoke about the difficulties in performing everyday tasks with reduced language proficiency. This was further complicated by regional accents and colloquialisms among colleagues and older people under their care. Older people highlighted language and communication as being essential for good quality care. Carers speaking to each other in their native language when providing care was seen as inappropriate and potentially distressing. Challenges around language and communication underlined many of the issues concerning labour market and social integration.
- Poor knowledge of Irish culture was identified as a problem in employing migrant care workers. Issues surrounding culture and language sometimes undermined the sense of shared cultural experiences for the older person in particular. Ultimately, these combined problems had the potential to compromise the integrity and person-centredness of the caring relationship, complicating many routine activities. Having common historical reference points was thought to inform an understanding of what it is like to grow old in contemporary Irish society. Religion and shared religious beliefs were found to facilitate a greater acceptance of migrant carers by older people.
- Differences in philosophies of care were also apparent. This was particularly the case for migrant carers who had been recruited from acute settings and for those carers coming from countries with mainly informal systems of care for older people. Some of these carers had no professional experience of caring for older people in long-stay settings and more did not always understand why older people now under their care in Ireland could not be looked after at home by their families.
- Being cared for by people from different countries provided an opportunity for cross cultural learning. Parallels were drawn between the value systems of some nationalities and what was perceived to be our own family centred approach to caring for older people in the past.
- A sense of shared experience with migrant workers with respect to emigration was evident among some older people in the study. There was a strong sense of admiration and respect for labour migrants who worked and saved money to support family in Ireland and in their home countries.



- The majority of employers surveyed stated that the quality of care did not change with the employment of migrant care workers; quality was at the very least maintained and sometimes improved. However, there were issues with respect to training and orientation that impacted on the short-term proficiency of migrant carers to deliver appropriate care. Education and training were identified as important to instilling a person-centred care approach to care for older people among both migrant and indigenous carers.
- The nursing home residents spoke very highly of the care they received from migrant carers, while the prospective users of care (community residents) found it difficult to gauge the impact of migrant care workers on the quality of care.
- Both employers and older adults stated that without the migrant care workforce there would be a shortage of care staff to care for older people in Ireland and that many of the current issues around migrant carers caring for older people related to broader problems in the older adult health and social care sector concerning funding and prioritisation. A number of migrant carers questioned the value that is placed on care for older people in Ireland, when the rates of pay for such a physically and emotionally intensive role are generally so poor in the sector relative to other jobs.
- Older people did not believe that the ageing population was prioritised on the national agenda, whether in respect to social valuation or health and social care provision.

Policy and Regulations

- The impact of immigration and employment regulations on migrant carers and employers was substantial across both work and social domains.
- For employers, the primary issues included delays in processing applications, time-consuming paperwork and uncertain application criteria. Due to work permit regulations, only registered nurses were being recruited from outside the EEA and 50% of all care staff in an organisation had to be from within the EEA. This was seen as unnecessarily restrictive, ultimately compromising the quality of an organisation's staff.
- Restrictiveness, bureaucracy, frustration and delays in processing applications characterised the experiences of many migrant carers with regard to employment and immigration regulations. These aspects of the regulatory system reduced the opportunities for employment, increased the vulnerability of people in abusive situations and contributed to care workers becoming undocumented. The short-term duration of the work permit system may also threaten the continuity of care for older people.
- The conceptualisation of skill level with respect to care giving and in turn immigration channels need to be reassessed. The requirements necessary to be a good carer are not just reliant on professional qualifications, but are dependent on the commitment of the carer and a set of personal characteristics that include compassion and kindness. Therefore personal care, even for those without a professional qualification, should not be conceived in the traditional sense as low-skilled. The current immigration channels for care workers should be re-examined with this in mind.
- Issues surrounding long-term residency and family reunification impact on the lives of migrant carers outside of the working environment and resulted in feelings of uncertainty with respect to staying in Ireland. That said, the majority of migrant carers intended to be still living in Ireland in five years time. For some people, Ireland was described as a second home, where feelings of integration and a sense of belonging were becoming increasingly strong.

- The implementation of the 'National Quality Standards for Residential Care Settings for Older People in Ireland' should assist in ensuring the delivery of high quality care in residential care settings and should impact positively on migrant carers in those settings. The absence of any form of regulation in the private home care sector means that older people may now be more at risk in their own homes than in long-stay settings.
- The adoption of FETAC level 5 training across all public facilities and in many private nursing homes is a positive development. However, minimum standards of training need to be set for all care positions and across all settings in the older adult health and social care sector.
- There is extensive legislation and a number of statutory and non-statutory organisations to support the protection of migrant carer employees in Ireland. However, there are issues with respect to enforcement and inspection that need to be addressed. These issues are particularly pertinent in home care settings, where employment law breaches are much more difficult to identify.
- The older adult health and social care sector in Ireland is disadvantaged and marginalised. While political and public discourse has emphasised the need to prioritise older adult care, there has not been a corresponding policy effort to address the current problems in the sector. This is exemplified by the under-funding, poor career pathways, lack of prestige and deficient regulatory structures that characterise the older adult care sector. Policy for older adult care suffers from a narrow and reactive focus that has a tendency to reinforce the negative perceptions of caring for older people.
- The disadvantage of the older adult care sector exacerbates the issues surrounding migrant carers caring for older people and compounds the marginalisation of foreign national carers where it exists. It is both helpful and necessary to consider the problems that affect migrant carers in the context of an already fragmented service provision for older people. The lack of appropriate resources and support structures for migrant carers, their employers and the older people that they care for could prove detrimental to the future sustainability of the migrant care workforce.
- While there is significant overlap between policy and legislation for older adult care and for migrant carers, the absence of an integrated approach has meant that many of the existing systems and structures operate in isolation. If this strategy, or lack of strategy, continues to be a feature of the sector, the issues and challenges highlighted in this report will only become more serious and the opportunities for migrant workers will become fewer.



Recommendations

- 1 The lack of prioritisation of the older adult health and social care sector underlies and exacerbates many of the issues concerning migrant health and social care workers in ageing societies. Older people have not been a priority in Ireland and resource allocation has not been adequate. Any debate on migrant care workers within the system must take account of that fact. The promised National Strategy for Older People is overdue, but when it is eventually published it needs to provide clear resourced pathways to greater person-centred care for older people that acknowledge the role and potential of migrant carers.
- 2 While the National Intercultural Health Strategy 2007-2012 recognises the need for a focus on migrant carers in Ireland, there must be a coherent strategy to address these issues in particular contexts. More precisely, the personal nature of health and social care provision makes it essential that respect for racial and cultural differences are understood to encompass both the providers and recipients of care. Older residents and their families need to be made aware of cultural changes taking place within care organisations, particularly with respect to the ethnic and cultural mix of staff, and must be assisted in making the necessary transition that allows for harmonious and mutually beneficial relationships to evolve.
- 3 The migrant care workforce is not receiving sufficient levels of support to negotiate current and future challenges in the older adult health and social care sector. Increased support structures for migrant carers and other staff are required for training (e.g. language, social care skills and approaches to care), orientation and integration purposes (e.g. cultural awareness programmes and cross cultural learning).
- 4 Although systematic discrimination does not characterise the experiences of migrant health and social care workers in this study, there is sufficient evidence to suggest that stronger regulations governing worker discrimination in care environments – including home care settings – are necessary. Appropriate structures for the reporting of racial abuse and labour exploitation, wherever it occurs, should be put in place at organisational, regional and national levels.
- 5 The absence of regulations for home care delivery mean that quality of care may be compromised for both older people and care staff. New regulations for home-based care are necessary to protect older people and their carers.
- 6 The present channels for information provision on migrant’s rights and entitlements are not effective, resulting in migrant carers not always being fully informed with respect to what constitutes rights violations in the Irish labour market. A reform of existing processes is necessary to address the current deficiencies in information.
- 7 Existing employment and immigration regulations negatively impact on the effectiveness of older adult health and social care, increase the vulnerability of carers, and threaten the stability of the migrant care workforce with respect to decisions to remain in the sector and to stay in Ireland. There needs to be a more coordinated and integrated approach to policy development across the ageing, migration and employment domains, particularly in relation to long-term residency, family reunification, efficiency of the permit system, and the conceptualisation of care skill level.
- 8 The potential for migrant workers to be marginalised within a host country, through discriminatory practices, weak regulatory structures and poor policies, is substantial. Working in the older adult health and social care sector, which has largely been underfunded, increases that potential for marginalisation, and in effect frames the experiences of migrant carers in the labour market. When older people, who are ultimately the consumers in this sector, have had to endure fragmented, under resourced and inequitable care provision, the value we place on their care givers, represented through support and training structures, pay and conditions and protection, also comes under question. Significant public investment in older adult care is required to provide the physical infrastructure and human capital necessary for high quality care.

Footnotes

- ¹ The categorisation of foreign national, as opposed to foreign born, is used in this report because much of the relevant data in Ireland is based on nationality. In addition, the categorisation of foreign born may include Irish citizens, who are not the focus of this report.
- ² This chapter has been written by *Aoife Callan* of the *Irish Centre for Social Gerontology, National University of Ireland Galway*
- ³ Data on disability was derived from answers to questions on long-lasting conditions (question 14, 15 and 16) of the 2006 Census of Population questionnaire.
- ⁴ There were five health status categories: Very good; Good; Fair; Bad; Very Bad.
- ⁵ Receipt of Carer's Allowance was not considered payment for care provided.
- ⁶ This chapter has been written by *Piaras Mac Éinrí* of the *Migration Studies Unit, Department of Geography, University College Cork*
- ⁷ This chapter has been written by *Alan Barrett* of the *Economic and Social Research Institute, Dublin* and *Anna Rust* of the *Irish Centre for Social Gerontology, National University of Ireland Galway*.
- ⁸ It could be the case that expansion of the health and social care systems will occur through the private system. Even if this is the case, it could well be the case that the government would come under pressure to ease immigration restrictions if the cost of such care was rising because of labour supply constraints.
- ⁹ With the highest fertility rate in the EU- 25, Ireland's demographic projections are positive compared with the rest of the region, and the country currently has less need of migration as a means of replacing the dwindling working-age population (NESC 2006). However, as will be seen in the subsequent sections this will change.
- ¹⁰ The discussion in this section is largely based on Barrett and McCarthy (2007b).
- ¹¹ This 4:1 ratio approach in projecting care demand has been used by Barrett and Bergin (2005) and by Barrett et al (2007)
- ¹² Other sources suggest that a higher proportion of health and social care workers may be foreign. For example, according to the Irish Nursing Board 21% of nurses are foreign. In addition, the employer survey conducted as a part of this study found that there was a higher concentration of migrant care workers working with the over 65s than for the sector as a whole; the ratio reported was 31.6% foreign national to 68.4% national for the older adult care sector. As the figure we are using is at the lower end of range, our results can be viewed as providing a lower bound estimate of the current and future demand for foreign health and social care workers.
- ¹³ Extracted and summarised from; *Gordolan, Lourdes (2008). Source Country Report: The Philippines. The Role of Migrant Health and Social Care Workers in Ageing Societies-August 2008.*
- ¹⁴ Extracted and summarised from; *Goździak, Elzbieta (2008). Source Country Report: Poland. The Role of Migrant Health and Social Care Workers in Ageing Societies-August 2008.*
- ¹⁵ Dr. Adeline Cooney, School of Nursing and Midwifery at NUIG, contributed to the writing of this section.
- ¹⁶ Dr. Adeline Cooney, School of Nursing and Midwifery at NUIG, contributed to the writing of this section.
- ¹⁷ Although efforts were made to include undocumented workers caring for older people in this research, it was not possible to identify or recruit these individuals. Data on undocumented workers in this sector is primarily anecdotal, with little certainty about actual numbers.

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Appendix A: Employer Postal Survey

Employers' Survey

The Role of Migrant Health and Social Care Workers in Ageing Societies

The Irish Centre for Social Gerontology, at the National University of Ireland Galway, is partaking in a collaborative cross-national research project on *'The Role of Migrant Health and Social Care Workers in Ageing Societies'*. The research, which is also being conducted in the UK, Canada and the US, explores the implications of the recruitment of migrant workers for the delivery of health and social care to older people, for the living and working conditions of the migrants, and for immigration and integration policies. We are contacting all long-stay care facilities and home care organisations in Ireland as part of this survey. The information gathered will be used to guide policy for the future development in this sector. In the context of this study, 'migrant workers' refer to foreign national citizens working in Ireland.

As an employer in the older adult health and social care sector, your views are critical to this process and we would be very grateful if you could complete this questionnaire. Even if you do not employ migrant care workers, your response will provide vital information concerning the perspective of employers in this research. The details you provide will be treated in **strict confidence**. It will **not** be possible to identify your specific response or your facility/organisation in the final report.

Most questions can be answered by ticking one or more boxes or entering brief data. The questionnaire should be completed **by the owner of the facility/organisation, the Director of Nursing, or the person in charge in your long-stay care facility/organisation**. Please return the questionnaire in the stamp addressed envelope. Thank you very much for your time in filling in this questionnaire. The results of the study will be made available when the study is complete.

Profile of Your Long-Stay Care Facility/Organisation

1. Please tick the category which best describes your long-stay care facility/organisation
(please tick one box only):

Long Stay Care Facility

- Public (HSE) Extended Care Facility

 Voluntary Geriatric Hospital
 Public (HSE) Welfare Home

 Voluntary Geriatric Home
 Public (HSE) District Hospital

 Private Nursing Home
 Public (HSE) Community Hospital

Home Care

- Private Home Care Organisation

 Voluntary Home Care Organisation
 Private Home Care Agency

 Other _____
 Voluntary Home Care Organisation

2. Where is your long-stay facility/organisation located?
(please tick only one box):

- Urban (City)

 Village
 Large Town (10,000 -30,000 people)

 Rural Countryside
 Small Town (1,500 -10,000 people)

3. What is the total number of older people (aged 65 years and over)
in your long-stay care facility or cared for by your organisation?

4. Please indicate the number of older adults (aged 65 years and over) under your care
who fall into each of the following dependency categories
(if none, enter zero):

Category	Number of clients/residents
Low dependency	
Medium dependency	
High dependency	
Maximum dependency	

Profile of Your Workforce

5. How many people in each of the following categories work in your long-stay care facility/organisation? (if none enter zero):

Category	Full-Time	Part-Time (less than 25 hours a week)
Registered nurses		
Care assistants		
Total		

6. How many migrant care workers in each of the following categories work in your long-stay care facility/organisation? (if none enter zero):

Category	Full-Time	Part-Time (less than 25 hours a week)
Registered nurses		
Care assistants		
Total		

7. If migrant care workers are **not** employed in your long-stay care facility/organisation, please explain in the box below and then proceed to question 11.

If you do employ migrant care workers proceed to question 8.

8. If you employ migrant care workers, what are the top three source countries that migrant care workers in your long-stay care facility/organisation come from? Rank the countries from 1 to 3, with 1 representing the primary source country for migrant employees.

Rank Order of Countries	Registered Nurses Countries of origin	Care Assistants Countries of origin
1.		
2.		
3.		

9. How many migrant care workers (nurses and care assistants) have left your long-stay care facility/organisation in the past year? *(If none, enter zero).*

10. How many new migrant care workers (nurses and care assistants) have you employed in the past year? *(If none, enter zero).*

Irish Care Workers

11. Do you have difficulty employing Irish care workers from the following categories?

Please tick 'Yes' or 'No' for each care worker category.

	Yes	No
Registered Nurses	<input type="checkbox"/>	<input type="checkbox"/>
Care assistants	<input type="checkbox"/>	<input type="checkbox"/>

If **yes** to either category, indicate your level of agreement with the statements on the following page.

If **no** go to Q12

Irish care workers are difficult to employ because:	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Of the general shortage of Irish care workers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Of the shortage of Irish care workers with the right skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They are not willing to work nights and shift work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They are not committed to caring for older adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They demand higher wages and benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High turnover	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are too few opportunities for promotion in older adult care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If there are additional difficulties with employing Irish-national care workers, please specify in the box provided.

PLEASE NOTE: The remainder of the questionnaire is only relevant to those employers who currently employ migrant care workers.

Therefore if you do not employ migrant care workers, the questionnaire is now complete: Please return it in the envelope provided.

Employing Migrant Care Workers

12. Do you use recruitment agencies to help you employ migrant care workers?

(Recruitment agencies refer to companies that manage the recruitment process of workers for an employer.)

Yes No

If **yes**, please indicate your level of agreement with each of the following statements.

If **no** proceed to Q14.

Recruitment agencies are beneficial because:	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
They are cheaper than self-managed recruitment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is difficult to recruit migrant workers through the normal process, e.g. advertising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They take care of immigration paperwork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High quality employees are ensured	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They have high ethical standards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What is your general experience with recruitment agencies?

13. Are recruitment agencies more helpful for hiring migrant nurses or migrant care assistants?

Please tick only one box.

- Nurses No difference
 Care assistants Don't know

14. Do you use migrant care workers who are contracted from an outside employment agency?

(An employment agency employs workers directly, who can be contracted to other organisations for a fee).

- Yes No

If **yes**, please indicate your level of agreement with each of the following statements.

If **no** proceed to Q16.

Employment agencies are beneficial because:	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
It is easier to let contract workers go	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contract workers cost less	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They are cheaper than self-managed recruitment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They reduce paper work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What is your general experience with employment agencies?

15. Are employment agencies more helpful for sourcing migrant nurses or migrant care assistants?

Please tick only one box.

- Nurses No difference
 Care assistants Don't know

16. The following statements describe possible advantages of employing migrant care workers. Please indicate your level of agreement with each of the statements.

Statements	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Migrant care workers have a good work ethic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migrant care workers are willing to work all shifts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migrant care workers are committed to caring for older people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migrant care workers are loyal to the organisation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migrant care workers have better personal contacts for hiring other migrant workers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migrant care workers have the right skill sets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migrant care workers are respectful and caring towards older clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migrant care workers are willing to learn new skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migrant care workers accept a lower wage than Irish care workers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migrant care workers are willing to live in	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If there are additional advantages to employing migrant care workers, please specify in the box provided.

17. The following statements describe possible challenges of employing migrant care workers. Please indicate your level of agreement with each of the statements.

Statements	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Migrant care workers have poor English language proficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is higher turnover amongst migrant care workers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migrant care workers have a poor knowledge of Irish culture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migrant care workers are not-well accepted by older people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migrant care workers show a lack of assertiveness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migrant care workers show a lack of decision making skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migrant care workers require extra job training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migrant care worker qualifications are not readily accepted in Ireland	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Government regulations make hiring migrant care workers difficult/risky	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If there are additional challenges to employing migrant care workers, please specify in the box provided.

18. What are your experiences with government regulations for hiring migrant care workers?

Please tick only one box.

- No problems Major problems
 Minor problems Don't know

If you have experienced any problems, please indicate your level of agreement with each of the following statements.

Regulations for employing migrant care workers are difficult because:	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
It is costly to apply for the necessary approvals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The paperwork is time consuming to complete	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is uncertainty caused by delays in visa processing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The criteria for application causes uncertainty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is uncertainty about the legal status of migrants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Of possible penalties for hiring unauthorised migrants workers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list any other issues you have with regulations for employing migrant care workers?

19. What impact has the hiring of migrant workers had on the quality of care provided to older people by your long-stay care facility/organisation?

Please tick only one box.

- Quality of care greatly improved Quality of care reduced
- Quality of care improved Quality of care greatly reduced
- Quality of care not changed

20. What has been the impact of hiring migrant workers on internal staff relations?

Please tick only one box.

- Staff relations are far better Staff relations are worse
- Staff relations are better Staff relations are far worse
- No difference in staff relations

A small number of survey respondents will be contacted by telephone for further discussion on this topic.

Please tick the adjacent box if you **do not** want to be contacted.

Thank you for taking the time to complete this survey. Your contribution is much appreciated.



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