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## *Managing for quality aged residential care with a migrant workforce\**

NYEMUDZAI ESTHER NGOCHA-CHADEROPA AND BRONWYN BOON

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### **Abstract**

Given the growing demand for aged residential care facilities in Western industrialised economies, the adequate staffing of these facilities is a growing concern. Increasingly migrant care workers are being employed to fill the local labour shortfall. In this paper we present findings of a qualitative study exploring how managers of aged residential care facilities work to ensure consistent delivery of quality care through their migrant care workers. The issues raised by the 16 managers cluster around three themes: communication and language barriers; racism by residents, families and managers; and underemployment of tertiary qualified migrant care workers. In addition to issues of quality care delivery, concerns around migrant employee well-being are seen to be difficult to avoid.

**Keywords:** healthcare diversity, human resource management

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### **INTRODUCTION**

It is well established that Western industrialised societies are ageing. Improved access to better nutrition, medical care, and a growing awareness of the importance of healthy eating and exercise have all contributed to increased life expectancies (Stone, Dawson, & Harahan, 2004; Hussein & Manthorpe, 2005). This has led to an increase in the numerical and proportional quantity of over 65-year-olds (Thornton, 2010; Clarke & Hill, 2012). A measure of this demographic shift is a fall in the global potential support ratio of over 65-year-olds per under 65-year-olds; in 1950 the ratio was 1:12, in 2050 it is estimated to be 1:4 (Badkar & Manning, 2009). While this reducing support ratio has major implications for Western economies and societies in many areas, it is the growing demand for aged care services that provides the context of this paper (Clarke & Hill, 2012; Human Rights Commission, 2012; Kaine & Ravenswood, 2014).

One approach to meeting the increase in demand for aged care services is the 'ageing in place' strategy. While there is some variation in how this strategy is operationalised internationally, in New Zealand the policy 'aims to encourage and assist older people to remain in their own homes, in order to enhance their sense of independence and self-reliance' (Davey, 2006: 129; Lazonby, 2007). Running along-side this home-based option, however, is the increasing demand for institutional care for the high-dependency elderly (Lazonby, 2007; Thornton, 2010).

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\* The author confirms that this manuscript has not been published elsewhere and is not under consideration by another journal.

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A significant concern emerging in the global aged residential care (ARC) sector is the insufficient supply of care workers to match this growing demand (Badkar, Callister, & Didham, 2009). The main reasons cited for this gap are the poor terms and conditions (Eaton, 2005; Hussein & Manthorpe, 2005; Cangiano, Shutes, Spencer, & Leeson, 2009; Human Rights Commission, 2012; Kaine & Ravenswood, 2014) and the low value and status associated with aged care work (Talley & Crews, 2007; Esplen, 2009; Ravenswood, 2011; Human Rights Commission, 2012).

The primary solution adopted by Western economies is to fill this ARC labour supply gap with migrant labour (Hussein & Manthorpe, 2005; Browne & Braun, 2008; Cangiano et al., 2009; Bourgeault, Atanackovic, Rashid, & Parpia, 2010), and New Zealand is no exception (Badkar, Callister, & Didham, 2009; Badkar & Manning, 2009; Williams, 2009; Callister, Badkar, & Didham, 2011; Human Rights Commission, 2012). A considerable body of literature on the phenomenon of migrant ARC workers has been accumulating over the last 20 years. The primary contributors to this literature are researchers of carer migration (e.g., Badkar, Callister, & Didham, 2009; Cangiano et al., 2009), and the consequences of migration on the aged care labour market (e.g., Hussein & Manthorpe, 2005; Browne & Braun, 2008; Howe, 2009). While more recent attention has been given to the impact of migrant aged care workers on the experience of the care work (e.g., Bourgeault et al., 2010; Timonen & Doyle, 2010; Walsh & O'Shea, 2010), there remains a paucity of discussion about the impacts of migrant labour on the management of quality care within ARC facilities.

At the heart of quality care is a caring relationship (Himmelweit, 1999). The increasing use of migrant labour is impacting on the development and maintenance of quality care relationships between ethnically diverse carers and residents (Kiata & Kerse, 2004; Eaton, 2005; Walsh & O'Shea, 2010). As Clarke and Hill (2012: 702) note, 'providing quality aged care services is...contingent on the availability of a qualified, experienced, and motivated workforce supported by appropriate systems and processes to ensure delivery of the required level of care'. Responsibility for delivery of a quality ARC service rests, inevitably, on the managers who are charged with providing these 'appropriate systems and processes to ensure delivery of the required level of care' (Clarke & Hill, 2012: 702). In this paper we contribute to the growing debate around migrant care workers by exploring how the managers of ARC facilities seek to ensure consistent delivery of quality care with a workforce that increasingly includes migrant carers.

Our paper reports on qualitative data gathered from a study of managers working within ARC facilities located in Dunedin, New Zealand. While the study is located in New Zealand, its findings are closely linked to broader debates around the use of migrant care workers in ARC facilities throughout Western societies. With a population base of 213,300 people (Statistics New Zealand, 2014), Dunedin's migrant worker inflow is smaller than Auckland and the other large international urban centres usually studied. In this sense, Dunedin provides a useful case study of migrant ARC workers in a medium-sized labour market catchment that does not include large communities of new migrants. In what follows, we review the literature on the organisational context and management within the ARC sector before introducing the concept of quality care that informs the analysis. Following an introduction to the empirical study, we present the managers' accounts of the particular issues that arise when managing migrant care workers.

## The ARC context

Compared to most OECD countries, New Zealand's proportion of people in ARC is relatively high (Thornton, 2010). Given that 5.9% of over 65-year-olds received institutional care between 1996 and 2006; only Norway, Sweden, and Switzerland were ranked higher (Thornton, 2010). 'While the long term trend of aged residential care utilisation has been generally flat over the last 20 years' the forecasted numerical and proportional growth of the over 65 year old population is anticipated to fuel an increase in demand for rest home and high dependency services over the next ten years

(Thornton, 2010: 6). Lazonby (2007: 36) notes that the New Zealand ARC sector 'is definitely one in the throes of considerable transition'. We have identified four key dimensions of this transition: ownership, intensity of care, an ageing workforce, and an ethnically diverse workforce.

The first dimension is ownership. Over the last 30 years the dominant ownership structure of the sector has shifted from single-site, non-profit providers to large privately owned and publicly subsidised facilities (Kiata, Kerse, & Dixon, 2005; Lazonby, 2007; Ravenswood, 2011). The 2010 profile drawn by Grant Thornton's Report (2010) suggests that approximately two thirds (68%) of the facilities are currently owned and operated by for-profit entities while only one third (32%) are run by non-profit entities (Thornton, 2010: 32). While the nuances of New Zealand's state subsidy of aged care fall beyond the parameters of this paper (see, e.g., Lazonby, 2007), a facility, either for-profit or non-profit, with fully occupied beds is better positioned to secure state funding (Ravenswood, 2011).

The second dimension of the transition is the increasing intensity of the care required for aged residents. Put briefly, like most Western societies New Zealand has an ageing population where more are supported into 'older-old' age through advances in medical treatments (Lazonby, 2007). A combination of individual preference and the ageing in place government strategy means that more of the functionally able older-old are receiving care in their homes (Davey, 2006). The people who enter the ARC facilities, therefore, are not only growing in numbers but are more likely to need high dependency 24-hr care (Lazonby, 2007; Thornton, 2010).

The third dimension of the transition taking place in the ARC sector concerns the workforce. Compounding the effect of fewer under-65s to service the increasing over-65s is the effect of an unattractive occupation. It is generally acknowledged that the low pay, low status, insecure working hours and demanding nature of the care work results in significant recruitment and retention issues for most ARC facilities (Kiata, Kerse, & Dixon, 2005; Callister, Badkar, & Didham, 2011; Human Rights Commission, 2012; Kaine & Ravenswood, 2014). New Zealand is not unique in this. Studies of ARC work in the United Kingdom (Cangiano & Shutes, 2010), the United States (Eaton, 2000, 2005), and Australia (Stack, 2003; Kaine & Ravenswood, 2014) also link poor recruitment and retention to low wages and poor working conditions in the ARC sector. A result of this poor recruitment of younger workers and the general ageing of the healthcare workforce (Lazonby, 2007; Badkar & Manning, 2009; Townsend & Wilkinson, 2010) is an ageing of the existing ARC workforce (Kiata, Kerse, & Dixon, 2005; Clarke & Hill, 2012; Human Rights Commission, 2012).

The final dimension is the increasing ethnic diversity of the ARC workforce. In response to an inadequately willing local labour pool, many Western countries, such as the United Kingdom (Cangiano et al., 2009), Ireland (Walsh & O'Shea, 2009), the United States (Eaton, 2000, 2005), Canada (Bourgeault et al., 2010), and Israel (Lecovich & Doron, 2012) have resorted to international recruitment of aged care workers. A similar profile is found in New Zealand (Badkar, Callister, & Didham, 2009; Williams, 2009; Callister, Badkar, & Didham, 2011; Ravenswood, 2011; Human Rights Commission, 2012). As the Human Rights Commission Report (2012: 103) notes:

The care sector in New Zealand has recruited heavily in recent times from the Philippines and the Pacific but also from a range of other places such as China. In the course of the inquiry we met carers from countries such as Nepal, India, the Solomon Islands, Cook Islands, China, South Africa and Japan.

These four key dimensions of change taking place within the ARC sectors of New Zealand and other Western economies place considerable demands on managers working within this sector. In short, these managers are held responsible for maintaining profit margins; they must provide an intense care service through a difficult to recruit and retain workforce; and the ethnicity of their workforce is increasingly diverse and different from their residents. As the New Zealand Human Rights Commission Report concluded, 'a new breed of health professional manager is required in aged care that meets the changing, complex demands of care and facility operation requirements' (Human Rights Commission, 2012: 94).

## Managing ARC

Change is seen to be a familiar challenge for healthcare managers (Briggs, Cruickshank, & Paliadelis, 2012). Inevitably, this change impacts on human resource management practices and processes. Put briefly, a corollary of increasing pressure on the efficiency and effectiveness of service delivery is the increasing importance of adequately skilled and performing human resources (Townsend & Wilkinson, 2010; Townsend, Wilkinson, Allan, & Bamber, 2012).

Unsociable and insecure hours of work, increasing workloads and chronically low and disparate wages for workers is a well stated human resource management concern in the ARC sector (Neysmith & Aronson, 1997; Eaton, 2005; Cangiano et al., 2009; Williams, 2009; Human Rights Commission, 2012; Kaine & Ravenswood, 2014). More recently, the ARC employment debate has begun to include attention to employee well-being. Ravenswood (2011), for example, draws a connection between employee participation and employee well-being. Clarke and Hill (2012), on the other hand, develop a model that emphasises the relationship between human resource practices, physical and psychological employee well-being and quality ARC service delivery outcomes. Clarke and Hill (2012) and Ravenswood (2011) acknowledge that the concept of well-being is not clearly defined within the literature or the workplace. In terms of the ARC context specifically, however, a more significant issue is the paucity of discussion about employee well-being for migrant carers.

Given that migrant carers are increasingly employed within ARC across the Western industrialised world, race, ethnicity and cultural beliefs on ageing and care will more frequently impact on the relationship between staff, managers and residents in these facilities (Kiata & Kerse, 2004; Bourgeault et al., 2010; Timonen & Doyle, 2010; Walsh & O'Shea, 2010; Human Rights Commission, 2012). Language fluency and cultural understanding, for example, have been identified as posing a particular challenge to quality care by migrant ARC carers (Kiata & Kerse, 2004; Bourgeault et al., 2010; Walsh & O'Shea, 2010; Human Rights Commission, 2012). In addition, migrant ARC carers report experiences of discrimination and racism by managers, colleagues and elderly residents (Kiata & Kerse, 2004; Walsh & O'Shea, 2010; Human Rights Commission, 2012). While the perceptions of migrant carers and their care recipients have been reported, less attention has been paid to the managerial implications of migrant care workers in the ARC sector.

Clarke and Hill (2012: 709) conclude that a critical issue for the provision of quality aged care services is the development and maintenance of a workforce that is 'committed and motivated, and that aged care employees are physically and psychologically capable of providing the necessary level of care'. Further, as a result of seeing racism impact on the care relationship, Kiata and Kerse (2004: 325) argue that 'an active debate about approaches to management to protect workers' is advantageous. This paper further develops the arguments generated by both Clarke and Hill (2012) and Kiata and Kerse (2004). Specifically, the analysis we present explores how managers in the ARC sector work to ensure consistent delivery of quality care through their migrant care workers. To fully appreciate the ARC work context, however, we turn now to briefly theorise the concept of quality care.

## Theorising quality care work within ARC facilities

Care work is generally thought of as nurturing work (England, 1992) or interactive service work (Leidner, 1993) that provides a face-to-face service aimed at developing the capabilities of the recipients (England, Budig, & Folbre, 2002). In the context of ARC facilities, the majority of the care work is for residents who have a reduced functional ability, possibly both physical and cognitive. The well-being of these residents, therefore, is dependent on help with all the basic activities of daily living (Fujisawa & Colombo, 2009).

In addition to the physical activities of caring there is the critical emotional dimension. Caring labour is described as 'a form of emotional labour because it requires both the emotion of caring about

and the activity of caring for another person' (James, 1989; Himmelweit, 1999: 36). It is at this point we start to recognise that ARC caring is fundamentally about the development of a caring relationship. In many service situations the employee's interaction with any particular person is limited in time and the relationship is highly transient. ARC care work, however, is defined by the creation of long-term service relationships that 'specifically involves the development of a relationship, not the emotional servicing of people who remain strangers' (Himmelweit, 1999: 35). Hence, we suggest the defining feature of long-term care is the human relationship between older people and their direct care workers (Eaton, 2000; Hussein & Manthorpe, 2005).

The relationship at the heart of quality ARC can be theorised in terms of two key dimensions: the technical aspects associated with thoroughness in clinical and operating activities, and the interpersonal dimension associated with socio-psychological qualities such as caring, courtesy, warmth, and approachability of the care-giver (Lim, Tang, & Jackson, 1999; Perucca, 2001). With the relationship between the carer and resident forming such an important aspect of quality ARC care, questions around the impact of an increasing ethnically diverse workforce on management for quality care are difficult to avoid. Accordingly, our contribution in this paper is a qualitative exploration of the implications of managing migrant care workers in the ARC context.

## METHOD

The sixteen participating managers work within nine of the 28 ARC facilities in Dunedin. In terms of bed-size, the facilities range from a multi-unit 128 bed to a single unit 26 bed facility. Five of these facilities provide more than one level of aged care, most include rest-home care and hospital care. Rest home care provides residents with medium-level assistance (Lazonby, 2007) that includes: preparation of meals, assistance with medication, laundry, and regular checking of the general well-being of the resident. Hospital care, on the other hand, is for residents with more 'limited capability to perform activities of daily life (washing, dressing, feeding), often needing 24-hour care' (Lazonby, 2007: 6). Nine of the participants work at the facility-management level and seven at the nurse-manager level. Table 1 presents a general profile of the 16 participants in terms of the facility ownership structure, the management position of the participant, their years of experience, the number of care-workers they manage, and the ratio of migrant worker to domestically born worker.

Owing to the explorative nature of the research agenda, data were collected using an individual semi-structured interview method. During the interview, each participant was asked to articulate their perception of managing migrant care workers. The questions were clustered into three key areas: (1) the employment of migrant carers in the ARC sector generally (e.g., Has the number of migrant carers changed over the period and what are the reasons for the change?); (2) the managerial benefits and challenges of employing migrant carers (e.g., Are there particular issues around communication when working with migrant workers?); and (3) the impact of migrant carers on the delivery of care (e.g., Does culture become an issue with migrant carers when working with residents and does that affect quality of care?). When a particular challenge or issue was raised by the manager, the manager was in turn asked to describe the strategy he or she employed to address this challenge.

## Data analysis

We adopted a manual thematic approach to analyze the data reported in this paper (Cassell & Symon, 2004; Braun & Clarke, 2006; Fereday & Muir-Cochrane, 2006). Thematic coding was undertaken in two discrete steps. Our broad aim for this study was to explore the specific issues managers of ARC facilities face when managing migrant care workers. For this reason the thematic analysis in step one was structured around two simple questions: (1) What particular challenges do managers describe

**TABLE 1. GENERAL PROFILE OF THE PARTICIPANTS AND THEIR MANAGEMENT CONTEXT**

<i>Ownership structure</i>	<i>Management position</i>	<i>Years in the position</i>	<i>Number of care workers</i>	<i>Ratio of migrant to domestic-born staff</i>
Public	Manager	15	23	0
Private	Manager	7	16	1:3
Private	Manager	9	13	6:7
Public	Nurse manager	2	54	4:23
Private	Manager	1.3	18	5:13
Church	Manager	5	65	2:11
Private	Manager	39	23	0
Private	Nurse manager	6	23	0
Church	Nurse manager	5	65	2:11
Church	Manager	13	88	13:75
Private	Manager	23	54	4:23
Church	Nurse manager	3	22	3:8
Non-religious non-profit	Manager	19	28	2:5
Church	Nurse manager	20	20	1:19
Church	Nurse manager	20	15	1:2
Private	Nurse manager	1 year	20	1:3

when managing migrant care workers?; and (2) What strategies do they report engaging to deal with these issues? The specific focus for this paper is the migrant-resident care relationship itself. The second level of analysis, therefore, was structured around two further questions: (1) What challenges to quality service delivery do the managers articulate in relation to migrant care workers?; and (2) What strategies do they engage in response to these challenges? Examples of text drawn from the interview transcripts are provided to illustrate the themes identified in our analysis presented below. The names of the participants assigned to these texts have been changed and their association to the facilities has been hidden to protect their anonymity. We present our findings of the managerial identification of challenges, and strategies for ensuring quality delivery of care in three sections: language and communication barriers, racism, and underemployment. The discussion that follows revisits these findings in terms of migrant employee well-being.

## FINDINGS

### Language and communication

Given the intensive and inter-personal nature of the caring relationship, it comes as no surprise that the quality of the communication between the ARC resident and their carers is a vital component of quality care. Consistent with previous studies (Bourgeault et al., 2010; Timonen & Doyle, 2010; Human Rights Commission, 2012) all the managers interviewed shared the view that there are significant challenges with the majority of the migrant carers' oral and written English communication skills.

Studies by Walsh and O'Shea (2010) in Ireland and Cangiano et al. (2009) in the United Kingdom found that knowledge of the English language, and the ability to understand and distinguish the various dialects, accents and colloquialisms of the residents were frequently a problem for the migrant carers. Possibly because the regional variation in accent and dialect in New Zealand is less marked than in Ireland and the United Kingdom, the managers of our study described the problem for the migrant care workers in terms of particular residents' incompetency with language, rather than accent per se.

As explained by Erin: 'In our dementia unit where our residents are old and suffer from memory loss and sometimes they speak incoherently... communication is a big issue especially with English being a second language for most of the migrants'.

In general, the managers who spoke of accent as a problem described it as a problem for the residents more than the carers. A number of the participants suggest that most of the elderly are not used to the different accents and sometimes this makes them lose their patience with their carers. Cameron in particular singles out a certain ethnic group of migrant care workers: 'They talk too fast and the tone and accent of some migrants contributes to communication challenges which make it hard for elderly residents with hearing problems to understand them'.

In an effort to ensure that the accent does not interfere with the caring relationship, Cameron adopts a coaching strategy with her migrants who have identifiable 'accent issues' or problems with 'speaking very fast'. As speaking very fast was a problem for everyone, including the native care workers, her strategy was simply to emphasise to all her employees the need to make sure that the other party involved in the communication act could understand what was being said: 'My strategy as the manager is to make sure you use simple English and speak slowly so that they understand'.

This issue of the migrants' accents, however, should not be over emphasised as the findings reflect that the managers are not unanimous in their opinion about the impact of accents on quality care delivery. Madison, for example, reasoned that a patient was more likely to be impacted negatively by a carer whose attitude was negative even if that same carer used an accent that the resident was used to, compared to another carer who might have a 'heavy accent' but show a very positive attitude to the patient. Similarly, Lindsay down played concern around accents with the observation that, unlike in the early days when they started employing migrant carers, her elderly patients were now getting used to hearing different accents because in most cases the people caring for them were migrants: 'Initially we had problem with the elderly complaining about the accent, but now we do not have any problems. They are now used to the accents and they don't complain that much'. In terms of communication it was the more operational risks that concerned the managers. These operational risks relate particularly to following instructions and writing reports.

Quality care delivery by unqualified healthcare professionals is heavily reliant on care workers following instructions. Lindsay, for example, perceives that the limitations of the migrants regarding English language proficiency are magnified by the fact that care work 'is a delicate job that requires that instructions are followed to the letter'. Several managers suggested that they are not always confident that their migrant carers actually understand the instructions given. Emerson, for example, made reference to a certain ethnic group of migrant carers whom she considers to be very hard working and dedicated to their jobs but seriously challenged in their English language communication abilities. This creates a threat to the quality of care delivered by such unquestioning people because:

You may think that you have made yourself clear to them when explaining how the work is done because some of them just nod enthusiastically... however, when they do the job, you realise that they did not understand your instructions. (Emerson)

This was followed by the observation that it was important for new carers to question when they did not understand because that was the only way they could ensure that quality care standards were adhered to. As Madison suggests, it is difficult for managers to know what to do in order to avoid carers acting in a manner that could be costly to the lives of the patients as well as the organisation: 'It is important to let them know that it is actually ok if they don't feel safe doing a task because sometimes they just do it because they feel they have to even when they don't feel safe'. While nothing untoward had actually happened as a result of this problem of poor communication, Emerson described it as 'an accident waiting to happen' because of the delicate nature of caregiving.

A second operational concern is in the quality of the migrants' shift reports. In a 24 hr/7 day a week operation written reports of a patient's ongoing health status is vital for continuity of quality care.

Because the care workers are unable to all meet face-to-face, a written report is the primary means for communicating these necessary details to the carers coming on duty. Bailey, for example, reports that: 'A worker who could not communicate well on paper and orally, represented a significant risk to the quality of care provided to the elders and ultimately to the organisation'. She adds that a simple mistake arising from poorly written accounts of the day's happenings could cost the life of the patients, some of whom she describes as 'frail' and requiring diligent care to avoid committing mistakes. As Casey suggests, this was especially worrying because care work reporting requires that all significant and seemingly non-significant occurrences are captured to enable the next person to discharge their duties effectively and efficiently.

It is important to note that over half the managers perceive their migrant workers to have a very high standard of written English proficiency and that they write very clear accounts of the day or shift's events. These views are echoed in findings of a study done on migrant workers in New Zealand by North (2007) in which 98.1% of employers in New Zealand reported that the English language of their immigrant employees was adequate for the job.

Several of the managers spoke of managing language and communication difficulties with their care workers primarily by avoiding this issue in the first place. Cody, for example, said that she did not have communication problems at her work because: 'When I do the interviews that is the time I do my screening... if I go ahead and give them a job, that means I am confident with their English'. Lee, however, said that she did not put too much weight on the communication skills of the applicant at the selection stage. Her strategy was to improve the language skills of the migrant carers by facilitating the integration of the migrants with the local employees once they started work. Aiming for the migrant worker to benefit from speaking with the local employees, she paired migrants with locals in her shift management.

### **Perceived racism and discrimination**

Consistent with previous studies (Kiata & Kerse, 2004; Walsh & O'Shea, 2010; Human Rights Commission, 2012) the second set of challenges to ensuring the delivery of quality care by their migrant ARC care workers is perceived racism and discrimination. The key challenge to quality care in this context is if these attitudes become the barrier to developing a trusting and warm caring relationship between carer and resident. Dakota, for example, believes that racism is rife at her facility but also many others as well. For this reason she feels it is important for managers not to 'sweep it under the carpet and pretend it is not happening'. While most of the other managers do not dispute the existence of racism at their facilities, many suggest that it is not as prevalent as it was 5 years ago. Cody, for example, observes that the majority of her residents are slowly getting used to being taken care of by people from different races and colours: 'Yes there were some issues of racism and discrimination. Most of these residents had never mixed with people from different races and colours in their lives. But now things have changed and we work as a family'.

Having said this, most of the managers agree that the attitudes of some of the residents, and in some cases their relatives, were a challenge and could easily be described as racist 'depending on one's definition of racism' (Christian). An important challenge in managing racism in the ARC facility is the management's reliance on the migrant worker reporting incidents of racism. While always making a point of resolving such cases by approaching the perpetrators once the case is brought before her, for Madison the problem is that very few of the migrants report these cases: 'I believe that there are many more incidences of racial abuse than are reported to me'. As Alex put it, 'How do you solve a problem that has not been reported to you?' For Lindsay, dealing with this reporting challenge began with creating trust with their migrant workers so they could freely express their fears without fear of victimisation.

All the managers were aware that the sources of racist attacks were varied and sometimes difficult to isolate. They did, however, identify that racism against migrant care workers could be practiced by residents, the residents' families, and by the ARC staff.

Racist behaviour by the residents generally takes the form of refusal of care or verbal abuse towards the care worker. While the responses did vary across managers, overall, we identified that four different approaches to managing this racist behaviour were articulated. The first, most passive approach, is to warn their new migrant care workers that if they come across any form of racism they should not take any notice of it, 'they should just ignore it'. They are to be 'patient' and show a lot of 'perseverance' as it was difficult to change the way different racial groups regarded each other (Drew). A similar rationale was also provided for racism due to the residents' dementia or mental instability (Alex). In this situation the migrant carers are advised to ignore the racial taunts because they are caused by issues beyond their control or influence. If the racism is seen to continue and is not easily tolerated by the migrant care worker, the suggestion is that the migrant worker should leave to gain employment elsewhere:

Sometimes you get to a conclusion that the interests of the employee are better served if the employee seeks alternative employment.... This is not to say I support bad treatment of the employees... sometimes you realise that you are dealing with issues that are way beyond your control. (Alex)

The second approach to resident-based racism is also passive but could be labelled 'accommodation'. In this approach a non-migrant carer would be allocated to the resident in question. Accommodating this form of racism was rationalised in terms of different historical norms and the elderly resident's inability to change:

I don't think it is easy to change these people... they are at a stage in their lives where it is difficult to change their views about life, about you and me.... Some of these people grew up in environments in which racism was not such a big issue... or if it was a big issue, very few people talked about it... its different today of course... as we see it today. (Bailey)

In a similar vein, Emerson had been proactive in dealing with racism by avoiding the employment of a certain ethnic group because of the tension she observed between some of her residents and carers. She discovered that this tension comes from these migrant carers triggering distressing flashbacks of the resident's traumatic war-time experiences.

The third more active approach seeks to integrate the migrant care worker into the facility. Cameron, for example, works to diffuse tensions between her residents and migrant carers by introducing the migrant carer to the residents and staff as soon as s/he arrives. This gives both parties time to talk and the opportunity to get to know each other:

I noticed that some of the racism is dealt with as soon as we employ someone new. By letting the residents know about the new employee and understanding a bit about them, reduced the funny comments being passed. In most cases these migrant care workers have a nursing background and once they hear about that they actually have respect for them. (Cameron)

The final approach is to defend the migrant care worker. Casey, for example, said that she was 'ruthless' with such cases and often adopted a hard stance by serving the resident's family members with written warnings as a way of curtailing recurrence of racially abusive behaviour towards their workers:

If it's somebody living with us we say 'sorry all our staff are equal' and we tell them to leave and find somewhere where they can do that. But no one has left; all they have done is change the way they treat our migrant care workers. (Casey)

Racist behaviour towards migrant carers can also come from the families of the residents. Casey, for example, reported that she had personally witnessed situations where relations of the elderly residents passed derogatory remarks directed at migrant workers:

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

All the managers agree that, at different times, they have come across difficult families who are unhappy having their family members being cared for by migrant staff.

While all the managers report that they make it clear to all their carers that they will not accept any show of racial intolerance and prejudice, a final source of perceived racism is at the unit management level. Nurse Managers act as operations managers in the larger ARC facilities. They oversee the performance of tasks, the allocation of tasks, shift management and other day to day issues at the facility. The reports of racism by Nurse Managers centre on the allocation of residents and the allocation of shifts. Christian, for example, reports that she received complaints from some migrant workers who perceive their unit's Nurse Manager allocates the most care-demanding residents to them. In addition, this same Nurse Manager is accused of:

changing the roster without even asking them. In most cases it was when a native New Zealander carer wanted a day off or a swap... the worker complained that this unit Nurse Manager changed the roster without consulting with them. (Christian)

To address these instances of racism, the managers institute strategies that are not always specifically targeted at the migrant care workers' complaints but are seen to provide fair and equitable patient and shift allocation for all care workers.

Sensitivity to the business of ARC, however, featured significantly in the accounts of managing racism. In other words, dealing with racism was at times felt to be in tension with the need to attract adequate volumes of business. For example from Cameron:

It is important to remember that we can only employ some of these migrants if there are patients to take care of... I also have to think about the family relations of my patients... they have their own expectations regarding how we should look after their relatives... it's not easy to balance these issues. (Cameron)

As a result, Cameron finds she is 'juggling' a lot of seemingly irreconcilable challenges. The facility relies heavily on word-of-mouth recommendations from family members to attract more residents. Her ability to deal with racism, therefore, is compromised by the pressure to keep residents and their families happy. Cody points out that the nature of the facility determines how the manager is able to deal with racism. She gives the example of a colleague who was managing an aged care institution where the patients owned the flats they were staying in. Any conflict due to perceived racism in this context invariably results in little attention to the carers' concerns.

A related concern is the importance of keeping residents and families happy so the facility does not receive negative attention from the media. Drew, for example, observes that if the concerns of the family are not adequately addressed, some families will air their grievances through the media:

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

## **Underemployment**

Along with language and racism, we found that the qualification profile is the third notable theme within the ARC managers' discussion of migrant care workers and quality care. While perceptions of the impact on quality care varies, it is generally acknowledged that a number of the migrant workers come with significantly more formal qualifications than the domestically sourced care workers. From Emerson, for example: 'In my whole experience as a manager here and elsewhere, I don't remember ever employing a New Zealander in possession of such qualifications'. While ordinarily the managers do not expect people with these qualifications to work as care workers, they acknowledge it is easier for domestic applicants to secure a job that matches their qualifications, than for migrants.

In terms of qualifications, we identified five categories for the 89 migrant workers across the facilities included in this study. The first group are migrants who come with high school certificate-level qualifications only. The second group are migrants working while studying for a New Zealand nursing qualification. The third group are qualified nurses, 18 from India and 15 from the Philippines, who are working towards their English language qualifications so they can practice nursing in New Zealand. The fourth and fifth groups are migrants working as carers who have come with tertiary level non-health qualifications gained overseas. While the migrants of group four are not engaged in study to gain further New Zealand qualifications, those in group five are. Table 2 provides a summary of the numbers of migrant care workers in each of these five qualification and work-study categories.

Of these five qualification-related categories, it is the two groups with non-healthcare related tertiary qualifications that we will focus on particularly in this section. While they represent 40% of the migrant care workers referenced in this study, we suggest they have the potential to pose the greatest challenge for managers. First, these migrants are working in jobs with qualifications that are higher than is usual or regarded as necessary for ARC work. As Christian notes: ‘This job is important... but frankly speaking it does not require one to be as educated as most of the workers I have here from other countries’. Second, unlike the qualified nurses or nursing students, the qualifications they have are nonhealthcare related. Bailey, for example, states that most of the migrant carers have some ‘excellent CV’s, never mind that these qualifications are not health care related’. Madison also observes that the migrants’ application letters often include some very prestigious jobs held in their home countries: ‘most of the times when you look at the applications of the migrant care workers they have better CVs and better referees from prestigious jobs that they had back home’. While 24 of these migrant carers are studying for further New Zealand qualifications, these are again nonhealthcare related.

A number of the managers recognise that this mismatch between qualifications and the demands of the ARC work has implications for migrant employee well-being and therefore the delivery of quality care. Madison, for example, shared her sense of the frustrations highly qualified migrant care workers

**TABLE 2. THE QUALIFICATIONS AND WORK-STUDY CATEGORIES OF THE MIGRANT CARERS**

Group number	Work-study status	High			Graduate	Post-	Masters	Total
		school	Diploma	Degree	diploma	graduate diploma	degree	
1	Migrants with high school qualifications; not currently studying	15						15
2	Migrants currently studying for a New Zealand health qualification	4	1					5
3	Migrants with health qualifications from overseas; currently studying for New Zealand English qualifications	3	14	8	6	2		33
4	Migrants with tertiary non- health qualifications from overseas; not currently studying			4	1	4	3	12
5	Migrants with tertiary non-health qualifications from overseas; currently studying for New Zealand non-health qualifications			7	2	9	6	24
Total		22	15	19	9	15	9	89

are likely to feel. Whereas, generally, people upgrade their educational qualifications so that they can assume better job positions or

management positions where they supervise others doing the work... If the truth be told, I am sure that their ambition is not to do a job like this ... If anything, the aim is to move away from such manual low paying jobs. (Madison)

Accordingly, she understands the 'frustrations of these highly educated people when they go to a foreign country and can't get a job they are qualified in'.

In tracing the implications of this qualification mismatch on the delivery of quality care overall, the managers present a more ambivalent position. On one hand, a number of the managers suggest that these nonhealthcare-related qualifications are transferrable. Lindsay, for example, suggests that the migrants in possession of higher educational qualifications appear to have many 'useful and important transferrable skills'. Some of the migrants she had employed, for example, had qualifications in business management and people management related courses. She believes that this knowledge and training in other fields has an advantage when forging good relationships with the residents:

When you have employees who have very good qualifications in management from overseas, it really helps because you can see the way they deal with conflict and also relate with residents. When it comes to training they are easy to train and they also come up with good ideas in meetings once they settle in. (Lindsay)

More than half the managers state that they could provide no evidence that the 'over qualified' immigrant carers' workplace behaviour was negatively influenced by doing a job 'beneath one's educational qualifications'.

On the other hand, however, concerns were raised over the amount of time migrants with tertiary level non-healthcare qualifications took in settling into the care work. Lee, for example, notes that these migrant carers took time to create relationships with their patients: 'Usually when they join the organisation they take time to create relationships with the residents because sometimes they take things to heart and they don't really feel like they should be doing that sort of work'. She perceives that this is due to the shock of doing a job they would never have considered doing given their high qualifications. 'But once they settle in they are fine', she adds.

Although the demands of ARC work will be felt by all care workers, be they domestic or overseas-born, the managers acknowledge that these qualities could well assume a greater significance for workers who feel over-qualified for the work. To summarise Lee's words, a key factor is the perceived drop in the migrants' career trajectory. As one acquires higher qualifications one also climbs up the social ladder. The higher one is on the ladder the more certain jobs no longer feature in one's career thinking. Lee believes that being an 'ordinary carer' is one of the jobs that falls outside the qualified person's career plan.

The low status of ARC work is well acknowledged and is invariably associated with the poor terms and conditions of employment and the difficulty of labour recruitment (Eaton, 2000; Cangiano et al., 2009; Kaine & Ravenswood, 2014). What is not generally discussed, however, is the social status implications of performing the tasks that make up ARC work. As Casey puts it:

Some of the tasks that have to be performed on a day to day basis are things many of us rarely want to do... except maybe when the person involved is your child... They need assistance with everything that we take for granted in our early years. (Casey)

She reports that some of the new migrant workers appear 'visibly shaken' at the end of the initial induction tour that takes in the full array of activities involved in caring for the infirm aged residents; including bathing, cleaning them after they have soiled themselves, as well as feeding them. She reports that on some occasions the new migrant worker failed to turn up the following day. While acknowledging that some of the domestically sourced employees also express shock during the

induction tour, Casey suggests the situation is worse in some cases with the migrant carers or applicants because of this qualification-work mismatch. All of the managers did say, however, that once the migrant workers got past the initial shock most of them are 'excellent at what they do'.

Most of the managers describe care work as 'stressful work', 'difficult', 'hard', and 'poor paying', 'not for the faint hearted' that require care workers to 'exercise patience' in the midst of the challenges. It is important to acknowledge that these issues are not unique to the migrant carers. Several managers, however, did make specific links between the qualification mismatch and work-related stress with the migrant carers specifically. Again from Casey: 'I can only imagine the kind of stress some of these foreign workers experience... I would also definitely be stressed if I found myself in this position'. Christian, on the other hand, relates the stress more specifically to anxiety about when they were going to be able to secure a job that they were trained in. She believes that any person could be stressed by doing a job that was beneath their training regardless of how easy it was to perform the tasks of that job. In her view the fact that caregiving was characterised by some difficult tasks was beside the point:

I understand where they are coming from. I can imagine doing a job that I have never imagined myself doing. Yes, they are very good qualifications and makes this job seem easy, the stress comes from just thinking you are now doing this sort of work. (Christian)

A difficulty the managers have in dealing with this issue is the difficulty of telling whether the migrants' delivery of care was influenced more by the stresses they were experiencing from the job situation or from their private social lives. As Bailey reports:

I walked into a room and found the carer who had always come across as cheerful and bubbly talking to one of our difficult patients in a very harsh tone... I could not understand most of what she said because she was speaking in her own language... I could however tell that she was very angry... The tone of her was not good at all... The moment she realised I was in the room standing behind her she changed and started speaking in English in a very polite tone... Mood swings are not good for this industry... These old people need caring people.. I know they can be difficult... but they are old people... what do you expect from them? (Bailey)

When asked, Bailey could not categorically link these 'mood swings' to stress caused by the nature of the care job. She did add, however, she rarely had had any complaints from her elderly patients about local New Zealand carers being abrupt or not making attempts to engage in conversation with them when performing various caregiving tasks.

In this statement from Bailey there is the recognition that the migrant care workers may be dealing with stress related issues outside of the ARC work itself. Confirmation of this and an appreciation of the specific migration-based stress felt by these care workers are beyond the scope of this study. In addition, it is important to acknowledge that all workers have to deal with stress from non-work related causes at various times in their working life. ARC workers, both domestic and overseas-born, will not be exempt from this. The key question for this study, however, relates to the manager's perception of the migrant carer's handling of the work-related stress and whether their reactions impact on the quality of care delivered.

## DISCUSSION AND CONCLUSIONS

In terms of challenge to quality care delivery, the managers participating in this study emphasise those that can be seen to impact on the interpersonal dimension of the caring relationship (Lim, Tang, & Jackson, 1999; Perucca, 2001). The more technical operational concerns around accurate following of care instructions and writing shift reports were raised as an important challenge to maintaining resident safety. Interference with the quality care relationship, however, is where most of the attention was focused. In particular, the challenges of accent and speed of language, racist-based rejection of care and abuse from residents and families, and the perceived stress and frustration of highly qualified migrant

carers were discussed. While strategies to deal with the communication issues and racism were presented, the perceived concerns of underemployment were acknowledged more than addressed in any direct sense.

Clearly, managing for quality care delivery is an important concern for managers and residents within the ARC sector. Employee well-being, however, must also be brought into the discussion. Here we adopt Grant, Christianson and Price's (2007) broad definition of employee well-being utilised by Clarke and Hill (2012) in their human resource management-employee well-being-quality service delivery model. Specifically, well-being is 'the overall quality of an employee's experience and functioning' (Grant, Christianson, & Price, 2007: 52) that 'incorporates the three key dimensions of well-being: psychological, physical and social' (Clarke & Hill, 2012: 704). In this sense, not only is employee well-being an important precursor to quality service (Clarke & Hill, 2012) it provides a valuable platform to identify and discuss the managerial implications of the labour market issues that plague the ARC sector more generally. Addressing the full range of concerns around poor terms and conditions, low value and low status of aged care work (Eaton, 2005; Cangiano et al., 2009; Human Rights Commission, 2012) is beyond the scope of this paper. The management of migrant care workers, however, forms an important dimension of these wider concerns. In identifying racism impacting on the care relationship, Kiata and Kerse (2004: 325) suggest that 'an active debate about approaches to management to protect workers' is advantageous. It is this call, and the argument by Clarke and Hill (2012: 702) that quality ARC service delivery is contingent on a workforce that is 'supported by appropriate systems and processes to ensure delivery of the required level of care' that informs the agenda of this paper. The findings reported in this study identify that despite the significant efforts by some managers, systems and supports for migrant employee well-being, particularly for racism and underemployment, are not well established in many ARC facilities.

If the use of migrant care workers is seen to be the solution for the labour supply gap, recognition of the particular challenges to employee well-being these workers and their managers must address will only increase. Clearly, some of the managers of this study are fully aware of the additional frustrations and stress migrant care workers bring to their care work. While communication barriers can be resolved through more rigorous language-based selection criteria and training programmes, it is obvious in this study that racism and underemployment are far more difficult to deal with through standard human resource management practices.

In terms of racism, Cameron captures the situation well through her description of juggling a lot of seemingly irreconcilable challenges. One challenge is the facility's competitive position in the ARC marketplace. Given the growing privatisation of the ARC sector (Kiata, Kerse, & Dixon, 2005; Lazonby, 2007) this preoccupation with filling beds can only increase. As reported by the managers, attracting adequate numbers of residents is reliant on the reputation of quality care delivery. Importantly, quality care delivery here is based on the perception of residents and their families. While some of the managers felt willing and able to challenge any racist behaviour on behalf of residents and their families, many felt constrained. On one level, the constraints are the mental and social conditions of the residents; such that the racism is deemed to be 'way beyond your control' (Alex). On another level, however, the constraints are the business-related concerns of customer perception and anxiety around bad publicity; such that addressing racism becomes a casualty of reputation management. In both levels the migrant carer well-being is disappeared.

In terms of underemployment the issues are no less fraught. The managers recruit migrants for care work because of inadequate supply of locally sourced labour (Badkar, Callister, & Didham, 2009; Cangiano et al., 2009; Walsh & O'Shea, 2009). Having intelligent and educated workers is understandably attractive to any organisation. As Lindsay notes, even the migrants with nonhealthcare-related qualifications bring 'useful and important transferrable skills' into the aged care context. A particular issue this raises for migrant ARC care worker well-being, however, is the prospect of

underemployment. We acknowledge that the actual perceptions of the migrant workers are not included in the data collected in this study. Several of the managers, however, did recognise that the shock some migrant care workers show when first confronting the caring tasks, the slower settling-in period, and possibly the handling of work-related stress could be linked back to the mismatch between care work and the qualifications and work expectations. In this, the ARC managers echo the link between a perception of underemployment and negative impact on job attitudes (Burriss, 1983; Feldman & Turnley, 1995) and job satisfaction (Khan & Morrow, 1991) already present within the general management literature. In so doing, this issue of underemployment speaks directly to Clarke and Hill's (2012: 709) observation that a critical issue for the provision of quality aged care services is the development and maintenance of a workforce that is 'committed and motivated, and that aged care employees are physically and psychologically capable of providing the necessary level of care'. Again, we can see in these findings that in terms of the employee well-being perspective, migrant underemployment is largely disappeared.

In that the ARC sector is known to have significant labour market concerns (Eaton, 2005; Human Rights Commission, 2012; Kaine & Ravenswood, 2014) the particular challenges to migrant care worker well-being and quality service delivery can easily be buried. With a growing presence of migrant care workers in the ARC workforce, however, greater attention to migrant-specific issues is becoming more important to address. In short, ARC managers are increasingly finding themselves at the centre as they balance the interests of their owners and residents with those of their ethnically and educationally divergent work force. The findings of this study support the argument that 'greater emphasis on the education and training of health managers and their continuing professional development is required if they are to manage increasingly complex, dynamic and changing health systems' (Briggs, Cruickshank, & Paliadelis, 2012: 641). In addition, these findings make it clear that further research examining both multi-stakeholder perceptions of quality care and migrant care workers' experiences of racism and underemployment is sorely needed.

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## CONFLICTS OF INTEREST

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