Skilled immigrant women carers in rural England and their downward mobility

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Abstract

An ESRC study that focused on the career trajectories of women immigrant care workers in a new area of settlement in England found that they had few opportunities to advance and that structural barriers were pervasive. Three major themes about factors for the women's downward mobility were discovered: 1) Social and economic discrimination in sending countries, 2) a predominant perception amongst British-born employers and the public that the women had poor English and qualifications, and 3) limited networks that enabled them to advance. The women devised enterprising strategies to survive, but few outcomes resulted from their efforts.

Keywords: skilled migrant women; barriers to advancement; migration in rural regions

Introduction

Recent studies of new migrant workers in England reveal that their trajectories are downwardly mobile because their low-paid jobs are incommensurate with their high skills and education levels (Marcova & Black 2007, Khattab 2006). Consequently, they are considered, 'the new underclass' (Goodchild 2007). Furthermore, third country migrant women in the European Union experience 'triple disadvantages' (Rubin et al 2008) which are exacerbated by regional and sectoral issues within the destination country. An Economic Social Research Council Study (ESRC) study[1] of thirty skilled women from both European Union and non-European countries, who were paid carers for the elderly in Cumbria, England concurs, that these women had few established support systems and opportunities to advance. The purpose of the study was to generate understanding about the career trajectories of skilled women immigrants settling in a rural region, to work as carers, and their networks and mobility patterns. Many immigrant women, even those who are highly educated, take jobs in the care industry as a way to advance in Britain. What opportunities, if any, does their care work lead to?

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[1] The study draws on two data sets, focusing on skilled women migrant care workers, which are part of a larger ESRC study that finishes in 2010, called, 'Home/Work: The Roles of Education, Learning and Literacy in the Networks and Mobility Patterns of Migrant Carers in Cumbria.'

To what extent does working in a rural area limit these women's self-determination strategies?

According to the 2006 Office of National Statistics, migrants comprise approximately 16% (100,000) of all paid care workers in England (see also, Cangiano et al 2009). There is greater regional variation; for example, in London, 68% of care workers are non-UK born (Gould 2007, Cangiano et al 2009). The Worker Registration Scheme shows that care work is one of the 8th most popular occupations amongst A-8 populations, with the Polish population at the top. Filipinos are the largest (10%) third country migrants in this sector (Gould 2007). A COMPAS study of migrant care workers (Canganio 2007) found that the northern region has fewer migrant care workers overall, but differences between urban and rural areas were not discussed. The assumption in policy studies is that British born workers are a stronghold in this region. This study highlights the issues of migrant carers in the northwest, particularly in rural areas.

Cumbria, in the northwest region of England, between the Penine Hills and the Irish Sea, gravitated from agricultural and sea manufacturing to concentrating on hospitality and care, after the foot and mouth calamity (2001) which struck the heart of its economy. The Lake District attracts tourists and the retired, making it a top location for hospitality and health care (Bennison 2008). British-born youth tend to leave because of the lack of universities and high-quality jobs. Without workers, Cumbria's new service economy would dwindle. Therefore, active recruitment of migrants has filled the gap and improved the capacity and quality of service. With the elderly becoming a burgeoning population in this region, migrant carers are recruited to work in its many nursing and residential homes as well as in domiciliary care (care to older people is provided in their homes).

Little is known about the trajectories of immigrant women who take jobs for which they are overqualified and the barriers they experience in developing their careers. Some research has indicated that policies focus on immigrants' social integration rather than their labour integration, and overlook the special conditions of women (Kofman & Raghuram 2006). Of the research on women immigrant carers and domestics, the focus is on those with less education (Kofman & Raghuram 2006). In addition, more attention is paid to women immigrants who settle in "global cities," (Sassen 1998 Datta et al 2006), rather than in rural areas (CRC 2007). Do high skill levels guarantee that well-educated women carers can advance in the absence of established ethnic networks and public services found in cities?

First, a look at the conditions within the care sector itself helps explain why professional migrant women (qualified nurses for example) are working in it and the issues that impact their advancement, especially in rural areas. As the industry expands to accommodate England's burgeoning ageing population, it is becoming privatised, technocratic, and efficiency-driven as it modernizes (Rainbird, Munro & Senker 2004). The following traits now characterize the industry as it is currently:

Market-based

Elderly clients on fixed incomes are called, 'service-users' who pay for packages of specific 'services' designed by social workers and themselves.

Personalised

Individuals and families choose amongst numerous care companies, often selecting the cheapest option.

Mobile

More people are living alone, requiring domiciliary care workers to drive to private residences, as well as use mobile technologies and mobile medical equipment.

Regulated

Legislation such as the Care Standards Act of 2000 means that increased qualifications are required for paid carers (50% of all carers in homes are mandated to have a National Vocational Qualification, NVQ at a level 2).

Literacy-Laden

Recorded documentation of care (from care plans to stool charts) is mandated by companies for accountability purposes and in lieu of lawsuits, to demonstrate compliance with new laws and to promote a professional/modernized care identity.

Task-Specific

As the care sector becomes consolidated as an 'industry', the tasks that carers provide compartmentalize personal care in terms of profits and time (bathing costs more than toileting because of the time and labour involved) (Twigg 2000).

Advocacy-based

Carers are positioned as guardians to clients, and are the 'ears' and 'eyes' of social workers, nurses, and doctors who depend on their observations of problems in order to change care plans or pursue abuse claims.

These traits characterize the workers as much as the industry itself. In aspiring to be marketable, attractive and cheap to consumers, care employers appear to seek out workers who are able and willing to comply with these demands; namely professionals from other countries with advanced English language and literacy skills and the professionalism to complete the required tasks. Furthermore, highly skilled workers hold professional dispositions, borne out of their education and public service backgrounds, and understand managerial and regulatory discourses, which are value-added incentives to employ them. It is not surprising then, that the care sector has one of the highest immigrant populations, many of whom are skilled women (Rhaguram & Kofman 2004). Furthermore, because these women participate in what Hochschild (Ehrenreich & Hochschild 2002) and Parrenas (2002) call, "global care chains" (having worked in care occupations previously, such as nursing), they recruit likeminded highly skilled family and

friends to work in social care. Although employers in both rural and urban areas depend on these global domestic care networks for supplying their workforce, this study shows that rural regions may rely on them more. Therefore, the global care chain, as this study shows, operates in Cumbria but in ways that may be different from urban regions.

Data and Methods

The study 'grounds' the experiences and perspectives of immigrant women in local contexts through ethnographic research and transnational migration literature was used to develop themes. Interviews with thirty highly skilled immigrant women (with university education and qualifications) who worked as carers in small and medium-sized care homes across Cumbria took place between 2007 and 2008. The carers were selected through purposive sampling to gain representation across nationalities and geographic areas within Cumbria and in care workplaces (Denzin & Lincoln 2000). The interviews focused on the women's reasons for migrating, their previous work and educational experiences, and the resources and information they exchanged between their network members both locally and abroad, as well as any further education, credentials they acquired so as to advance. The interviews were approximately one hour long, mostly face-to-face, with follow-ups, and twenty were transcribed. Patterns across the women's responses surfaced through a coding analysis (on Atlasti) of their strategies and barriers.

The care workers in the study

All of the women held university degrees and professional qualifications. Most of them were former health care professionals, prior to their arrival in England. The women were originally from Romania, Poland, the Philippines, China, and India. A few of them had lived and worked in other countries (like Israel, Singapore, and Saudia Arabia) before coming to England. The women's age range was between the mid-20s and early 50s. Most of them had arrived between 2005 and 2007.

Themes of Strategies and Structural Barriers

Three themes emerged about the strategies the women deployed in order to advance as well as the barriers they faced in the care sector and in a rural area: *Discrimination, Perceptions of Low-Levels of English and Qualifications, and Few Networks to Advance.* The themes emerged from the questions, which were: reason for migrating, the effects of previous education and work histories on present jobs, and their support networks.

Economic and social forces of discrimination

The first question, *reasons for migration*, revealed that many of the women faced either high unemployment, extremely low wages, and, ill-suited (to their degrees) job prospects in their country of origin, and moved primarily for economic reasons. They used *entrepreneurial* strategies, such

as the Internet, family, friends and recruitment agencies to look for work abroad, rather than relying on job centres, social workers, and welfare programmes in their countries. It was apparent that structural adjustment programmes (which often hurt women who work in social/health care sectors) compounded the discrimination (Sassen 1998); many women, particularly those in areas with high unemployment and with new degrees, could not locate jobs, and were desperate to find opportunities to practice. One former Indian nurse said: 'Before I was working another hospital for one month, but that's a very small hospital. I didn't get any more experience there' while a Filipina former nurse explained that the conditions in the hospitals were poor: 'I am a nurse, in a government hospital for five years. We work really hard, 50-60 patients in a ward. Not paid well.' In Romania, all types of services had skyrocketed over recent years and many goods were unaffordable to working-class citizens. The only way a family's economic status could improve, according to many of the women, was for one member to leave and send back money; as one Romanian nurse explained: 'because in Romania the life's quite difficult and hard in everyway, basically in everyway, school, food, house, clothes, medication, everything! It's very difficult.' Likewise, in the Philippines, a number of the women wanted their children to have a decent education and access to quality health care, which they could manage through migrating and remitting. While migration partially solved some structural barriers at a household-level, it did not appear to sustain the woman or her family on a long-term basis because problems in sending countries were worsening (with the recession), and barriers in the destination country were complex, to be discussed next.

Perceptions that the women possessed low levels of English language proficiencies and professional qualifications

The second issue was related to the question about the women's education and work histories, including their English language skills and usage. Although most of the women came to their jobs with professional qualifications, these were not considered legitimate in England. Many of the women were treated in their companies as if their prior skills, knowledge, and experience were poor, including their English language proficiencies. These judgments led many of the women to believe that if they could only communicate better about their skills to their employers, they would have professional identities at last and be protected and recompensed. The key, they felt, was to improve their English communication skills through studying, even though many of them had degrees in English, were assessed to have effective communication skills that matched industry standards, and spoke Periphery English (non-UK English dialects and accents). One woman who spoke English fluently said: 'I am worried because I have no UK certificate although I am register nurse in China, so that, it is important that I should improve my English language.' Furthermore, employers and community members, not used to hearing anything other than BBC or Cumbrian accents in this rural area, reinforced the women's sense of inadequacy by asking them to repeat themselves, and told them that they were not under-

standable. Therefore, the women tended to invest in short-term, low-cost strategies such as studying for English language tests, like the International English Language Test and taking English as a Second Language courses in further education colleges, or the NVQs, rather than gaining higher educational degrees, which they saw as an expensive, long-term and costly investment that they could not afford. This strategy appeared to backfire because it did not give them the educational 'capital' (Adkins & Skeggs 2004) they needed (advanced degrees) to progress in the health care labour market. In addition, although most of the European Union citizens took classes, they could not always persist because of their unpredictable schedules and on-call hours. Also, the recently implemented fee-based ESOL courses were costly. Therefore, their studies were episodic rather than consistent. Although there was a formal adaptation pathway for the nurses, without employer support, money, time, and travel incentives, not to mention restrictive immigration legislation, few of the women were able to pursue it as the tuition costs were high and it meant traveling long distances to get to classes. They often limited their movement due to worries about deportations and work permit cutbacks (Hattenstone 2007).

Few networks and supports to advance

The third issue relates to the question concerning the women's social networks in this rural area, and how it affected their abilities to advance. While a number of the women had relatives in other parts of Britain, they rarely saw them, and relied instead on their families abroad for emotional and material support, through phone calls and texting. They made frequent phone calls (sometimes every day if they had children) and their mobile phone bills were high. Their provision of support to their families from abroad could be considered a virtual "shift" (of work). One mother explained: 'I ask my daughter to get to school, text… I want to make sure she is safe. They even say good night and morning through texts--we are 8 hours behind. When I wake up I can see the texts and get piece of mind. That is the least I can do for them.' The women also sent home a good portion of their monthly incomes, and between high rents, utility bills, petrol, and numerous other extraneous costs, such as taking taxis due to poor bus services, few of the women adequately saved money. They were also so busy at work (over 40 hours a week), that they had little time for socializing, career networking, joining associations or taking university classes. They mainly saw one another and relied on their small collegial networks for survival needs. One former teacher felt like she was unable to advance in spite of working hard and establishing new networks: 'I have the impression, by doing things, meeting people, I will get somewhere. I hope. No results. I am still stuck in the job. Stuck in one place, not developing yourself. I'm so tired working these hours.' Little time was left for creating new networks that could enhance their careers. Although the women were not in global cities, they did form, what Saskia Sassen refers to as, "survivor circuits" (Sassen 1998). These 'care circuits' in Cumbria served the purpose of exchanging supports to survive, rather than to thrive. Furthermore, they benefited the employers

more than the women because of their recruitment function, and the fact that they rarely led them out of the care industry. A number of the women recruited friends and family to these jobs.

Conclusion: Little time for upward mobility

The women had little mobility, in terms of moving into better jobs and advancing into well-paying careers, like they had hoped. The main reasons for their lack of *social* mobility was due to their poor work conditions in their sending countries, the rural region they migrated to, the perception that they could not communicate effectively, and their relentless *physical* mobility in their current jobs---they were constantly rushing from one task or client to the next, covering large distances, and did not have the time or energy to invest in long-term advancement strategies. Their mobile phones they used all day were to locate clients and connect with them for the purpose of care. But the phones were also 'dislocating' in the sense that the companies sped up their movements by calling them, changing their work hours and break times, and ultimately bungling their schedules and plans. One woman described a frantic day: 'Sometimes you have no concentration, thinking about clients. The office calls you to go to this client on your break. Somebody can't work. Somebody's sick'.

The second-hand cars they purchased on loan through their companies and drove represented the 'dirty work of care' in that the time they used to get to and from clients' houses were not counted, and contributed to road congestion in a rural area known for unpolluted landscapes. Most of the women had little time to drive to cities and meet other people and to network into other circles. They did, however, use the internet in the library, and in other places, to seek out information about educational opportunities, communicate with employers, and search for jobs. However, the limited time they had to use it curtailed their efforts. Many of them believed that if they were in cities, they would have easier access to information and advancement opportunities.

While the women in this region 'bonded' with one another, and devised small collective strategies for surviving, structural barriers disabled them from accruing enough social capital for 'bridging' to better opportunities through networks that could sponsor them, and, they remained marginalised. Although rural areas are popularly thought of as having smaller but more friendly and tight communities, few women were deeply embedded into British-born networks, and no mention was made of agencies, associations, or formal services that reached out to help them.

While they transformed the care industry and rural communities with their hidden skills and knowledge, it was unacknowledged by employers and the public, and it was not viable for their careers. The study casts many questions about the gendered geographies of skilled migrant labour and the ways the global care chain reinforces downward mobility in rural areas for women.

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