Overworked & Underemployed, but Coping?

Underemployment amongst migrant care workers in the United Kingdom

Hannah Burd – 3744469 – Masters Thesis

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Abbreviations

CQC	*Care Quality Commission*. Independent national regulator of care homes.
EU	European Union
IT	Information Technology
NHS	*National Health Service*. State-run healthcare provider.
NVQ	*National Vocational Qualification*. 'Competence-based' qualifications which develop skills and knowledge alongside practical work.
UK	United Kingdom. Alternatively, Britain (encompasses England, Wales, Scotland and Northern Ireland).
UKBA	United Kingdom Border Agency. An Agency of the British Home Office which manages immigration.

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1.0 Summary

Migrant workers care for the British elderly in growing numbers. The wider context of this study is the dovetailing of the UK care and migration regimes; which are becoming increasingly interdependent. The report's introduction presents observations on the value attached to 'high skills' in current immigration policies and the concurrent low skilled label which care work has in Britain. Drawing on existing literature which describes the composition of today's caring workforce, a problem construction is formulated which identifies the potential of migrants with a range of existing skills and occupations to fail to gain work at their desired level or in the relevant sector. Care jobs sustain high demand, but appear unattractive to the local population. As a result, they are increasingly becoming a repository for migrants who cannot find work elsewhere or are making their first steps in the UK. This situation contains a number of potential antecedents of underemployment. The study aimed to find out whether underemployment was prevalent amongst migrant carers, what effect it had on their lives and careers and how they coped with it. The theoretical section of the report familiarises the reader thoroughly with the social scientific concepts of underemployment and coping strategies.

This research project represents a novel interrogation of Feldman's (1996) underemployment hypotheses. Whilst underemployment theory is gaining profile in the study of migrant employment patterns, it has not before been applied in the study of the growing migrant caring workforce. This study finds that it is a useful framework for identifying migrant carers' attitudes towards their jobs, career prospects, self-worth and making a new life in the UK. In order to extend underemployment theory's schema (which teases out the antecedents, experience and outcomes of underemployment), this study adds a coping strategies element. This has not only lead to the collation of fresh insights on

how this specific demographic manages to cope with the challenges of care work, but also gives a pragmatic element to the research. The empirical focus on coping allows the study to culminate with a presentation of concrete strategies which migrant carers have identified could help them sustain the provision of their vital services into the future.

The primary research itself involved in-depth interviews with twenty migrant carers working in the UK. They originally came from a range of countries including the Philippines, Malaysia, Nepal, China, India, Nigeria, Ghana, Zimbabwe, Sierra Leone, Romania and Poland. All three sectors of the UK care industry were also represented in their places of work; private, charity-run and state residential elderly care facilities. The interviews were held across the UK. A semi-structured approach was taken which encouraged career trajectories and migration narratives to emerge in detail. These were then closely analysed aided by coding software in order to systematically reveal indicators of underemployment and coping.

This exploratory study identified a number of intriguing insights on how migration and care work can conspire to produce underemployment. A particularly stark finding concerned the influence of discrimination on making migrants more vulnerable to employment at a lower hierarchical position than they had held previously in their careers. Non-recognition of foreign qualifications and problems unlocking expertise due to low-English proficiency also hampered migrant job seekers, and several reported a desperation to find 'any job' they could following frustrating dealings with immigration authorities. Once in care work, migrants identified with a number of Feldman's indicators of underemployment. Outcomes of this underemployment included depressed career trajectories, lowered job-satisfaction and increased intention to quit. Nonetheless, many carers were able to draw on a range of coping strategies which enabled them either to continue with work in a more satisfied way or escape the more frustrating aspects of their jobs. Overriding themes in the interviews were the role of a strong sense of professional identity, opportunities to (re)train, a sense of humour and the need for managers and co-workers to collectively reduce the external causes of underemployment. Policy suggestions for bolstering these are made at the end of the report.

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2.0 Introduction

Care of the elderly and immigration are two areas of social policy which dovetail increasingly in today's welfare states (Ungerson, 2004, Weicht, 2010, Van der Geest et al, 2004, Lyon and Glucksman, 2008). Migrants to European countries are swelling the elderly care workforce in growing numbers and the UK is no exception (Cangiano et al, 2009). Care work frequently falls into the category of jobs which native-born populations do not wish to do (May et al, 2007) and migrants reportedly face a range of work-related frustrations in this sector (McGregor, 2007, Doyle and Timonen, 2010). This study will ultimately focus on just one of those frustrations; that of underemployment. This phenomenon, and its implications for elderly care policy be the central concern of this study. It will be introduced following an initial familiarisation with the interlocking of the British care and migration regimes.

2.1 Background & Context

2.1.1 The UK Care Regime & Migration's Role

Reconciling work and care is a new social risk which has emerged in the recent decades for British families, and especially women. Under conditions of (some) diminishing gender inequality, growing numbers of women have been entering the labour market. Concurrently, ageing population demographics are becoming increasingly apparent (Taylor-Gooby, 2004, Lewis et al, 2008). Analysts of the UK care sector predict that demand for care services will double by 2036 from current levels (Laing & Buisson, 2005). Whilst care by families and friends remains the predominant source of provision for the elderly (Cangiano et al, 2009a), the UK has witnessed a marketization drive, particularly in the provision of institutional care. This tends to be reserved for the neediest and the 'older-old' (80+ years). Within the residential and nursing home sector, 92% of care places are now supplied by private and voluntary organisations, with the National Health Service (NHS) and local authorities providing the remainder (Cangiano et al, 2009a). The adult social care workforce is estimated to comprise 1.39million (top-level figure, 2006) and is projected to rise to 2.5million by 2025 (Skills for Care, 2005). McGregor (2007) observes that the sector has displayed increasing vacancy and turnover rates for health professionals, social workers, semi- and unskilled carers since the privatisation transition.

In order to fill the emerging deficit in carers for the elderly, applicants to begin work in care need hold no existing qualifications in the field and 'on the job training' of care assistants is widespread (McGregor, 2007). The UK has taken a commodifying approach (Ungerson, 2004), and has become one of the 'largest importers of professional health care workers in the world' (Wanless et al, 2006:131; Lyon and Glucksmann, 2008). This is not a new phenomenon; international doctor and nurse NHS recruitment schemes have existed for many years (Redfoot and Houser 2005). Yet the experiences of migrant workers in the care sector (as opposed to the more formal health sector) have been harder to document, given the increasingly fragmented, agency-run, privatised and sometimes informal nature of today's care industry.

2.1.2 The UK Migration Regime & Care's Role

The UK's migration regime increasingly prioritises the immigration of skilled workers (Home Office White Paper, 2002; Redfoot and Houser 2005, Kofman and Raghuram, 2005). The UK Border Agency (UKBA) uses a points based system[1] to calculate the 'value' of a migrant's skills and attributes based on their age, educational qualifications, previous earnings, work experience, sponsorship by an employer and ability to provide their own maintenance. Migrants who are highly qualified and earning substantial salaries before applying to work in the UK are given the widest access. This stems from a political intention for the UK to become a knowledge-based economy, capitalising on the globalising markets of research and development, particularly in science and engineering (OECD, 2002). The high-skills prioritisation policy has also been formulated in the context of political and public tensions regarding a perception of unwanted immigration; resulting in an increasingly sharp delineation being drawn between desired skilled migrants and undesired, so-called 'unskilled' migrants (Kofman and Raghuram, 2006, Bloch and Schuster, 2002).

Kofman and Raghuram, (2005) observe that this policy regime has an intrinsic gender dimension which affects skills classifications of caring jobs and impacts on the ability to fill vacancies in the care sector. Workers pursuing careers in science, IT and engineering (in which men are over-represented) are more likely to fall into high-skilled tiers. Simultaneously;

[1] http://www.ukba.homeoffice.gov.uk/policyandlaw/immigrationlaw/immigrationrules/part6a/Accessed30.06.12

> 'the skills required in educational and caring jobs, such as teaching and nursing, are considered to be inherent in their femininity and often collapsed into it, so that these jobs are primarily conceptualised as women's jobs and therefore semi-skilled rather than skilled (Ibid, also Hardill and MacDonald, 2000).

Furthermore, Kofman and Raghuram (2005) underline the importance of differentiating between 'skilled migrants' and 'skilled migration'. The latter, they argue, can occur without the attention of border authorities, as individuals ('highly-skilled' according to their education or expertise) may enter as spouses, students or refugees (Iredale, 2005). Failure to gain recognition or accreditation of their skills often means that migrants entering through these streams face challenges working in their original area of expertise. Subsequently, the caring industry has often become their only mode of easy entry to the labour market, prompting a cycle of deskilling (and reskilling) for these workers (McGregor, 2007). Women comprise 88% of the caring workforce and 17% of carers are ethnic minorities, although the composition of staff in any one part of the UK or individual care home varies (Cangiano et al, 2009). As care work is placed at the 'low end' of occupation scales, it is increasingly being affected by 'occupational polarization' (May et al, 2007). This process involves workforce bifurcation into high and low end jobs whereby native people tend to aspire to the former and a 'new migrant division of labour' occupy the latter (Ibid.).

'Supply and demand' are by no means the only immigration catalysts or drivers into care work (Portes and Böröcz,1989, Massey et al, 1993, Kofman and Raghuram, 2006). Migration's micro-motives are diverse and socially embedded; driven by a desire to materially improve the living standards of the migrant's family, realise the professional and empowerment aspirations of the individual, join social networks already established in the destination or escape adverse conditions in the home country, among other reasons (Doyle and Timonen, 2010; Portes and Böröcz 1989, Syed 2008). Nonetheless, with its demanding physical and emotional elements, work in care is by all accounts, not an 'easy' environment in which to begin life in an unfamiliar country (Ungerson, 2004; Van der Geest et al, 2004). Migrant workers in this sector report a range of frustrations including racial discrimination, poor employment rights or training, difficulties reconciling personal care obligations and a sense of being overworked and undervalued (Cangiano et al 2009a; Datta et al 2006, McGregor 2007).

2.2 Problem Construction

The above sections have described growing demand for elderly care, a shortage of workers for this sector, and resultant high recruitment of migrants to work as carers. Unlike in other sectors which the UK is attempting to 'grow' (clustered mostly in the knowledge economy), care work is not categorised as a highly skilled job. Entry requirements for care work are low due to labour shortages and this makes it a relatively barrier-free way to begin work in the UK. This is appealing to migrants seeking work who are unlikely to have entered the UK through highly skilled migrant channels. Yet, these categorisations, labels and easy access routes could mean that the qualifications and experience which migrant carers nonetheless do possess go objectively or subjectively unnoticed, and consequently undervalued. This creates a situation where migrant carers could perhaps be termed 'underemployed'.

Underemployment is deemed by a growing number of researchers to be a problematic phenomenon. It is a new concept with growing currency in studies of post-industrial labour experiences (McKee-Ryan and Harvey, 2011)and an umbrella term for a range of unsatisfactory worker experiences related to being undervalued or not having the opportunity to maximise one's working aspirations (Feldman, 1996). Underemployment is associated with job-related stress (Anderson and Winefield, 2011), higher turnover rates (Buzawa, 1984) and the wastage of valuable skills (Wilkins and Wooden, 2011). Whilst migrant workers have been identified as an 'at risk' group, more vulnerable to underemployment (Slack and Jensen, 2002; 2011), underemployment amongst this demographic in specific professions, such as care, has not received much focussed academic attention to date. The study will focus on the micro-level experiences of migrant carers. Taking their individual migration narratives as a guide, it will ask how migrants view their efforts working in the UK care industry in the context of their personal education and career trajectories. Furthermore, it will explore whether the UK care industry provides 'stepping stones' out of underemployment or 'entrapments' (Williams 2007) in work which does not maximise the skills which migrants bring to the UK.

2.3 Necessity & Objectives of the Research

There are two main objectives in this predominantly exploratory study. Firstly, micro-level experiences of underemployment, migration and care work will be documented. This is

appropriate given the absence of much existing research in this area of intersections. Secondly, the research should refine and extend existing theories of underemployment. The refinement process will involve challenging existing theories' applicability to the specific migrant experience, with attention to how this is filtered by the intersectionality of gender, race, class and origin. In order to extend underemployment theory, the study intends to move from descriptive understandings of causes and effects to a deeper appreciation of pragmatism and coping strategies when workers are faced with underemployment.

There is a final objective which has informed the research. As the following theoretical section will reflect, a large portion of the literature concerning care work and low-end migrant employment in general presents a decidedly gloomy view of worker experiences (see for example McGregor, 2007). In undertaking this research, pre-conceived ideas of the 'disempowered migrant' and 'drudgery of care work' have been eschewed as far as possible. Whilst this has not been replaced with an alternative normative expectation or agenda, the research upheld the objective of being open to falsification of these preconceptions, and wherever possible, to challenge them once equipped with empirical counter-evidence.

2.4 Structure

This report will proceed with a theoretical chapter which will first review the existing literature on the topics of migrant employment challenges and underemployment. It will then introduce two main theoretical models which underpin the analysis; Feldman's (1996) Underemployment Theory and Folkman et al's (1986) Coping Strategies schema. Subsequently the research methodology will be outlined and the theoretical terms operationalized. The second half of the report will concern the findings of the research. In these sections rich descriptions and insights on work in care will be presented, drawing from detailed interviews with twenty migrant carers. The report will culminate with closing observations regarding migrant carers' vulnerability to and coping mechanisms for underemployment. The final chapter will also raise some future policy and research suggestions in light of the study's insights on care work, migration and underemployment.

3.0 Theoretical Exploration

3.1 Unsatisfactory Employment, Immigration & Intersectionality

There is relatively little literature specifically discussing unsatisfactory work experiences amongst migrant carers in institutional settings (notable exceptions include Doyle and Timonen, 2010, McGregor, 2007, Datta et al 2006). Indeed, basic descriptive figures regarding even the proportion of foreign-born care workers in providing residential elderly care were unavailable until Cangiano et al's (2009a) recent survey (Huxley, 2006). There has been comparatively more focus on the experiences of migrant nurses and health professionals. Redfoot and Houser (2005) observe that a large number of overseas-qualified nurses begin work in British long-term care settings as the UK credentialing system compels them to undertake a period of adaptation involving working as an aide and working under close supervision (Ibid, Allan and Aggergaard, 2003). Even after this period, a disproportionate number (14% of foreign trained nurses vs. 5% of UK-trained nurses) continue to work in the long-term care sector, despite reports that they might experience a sense of deskilling and being undervalued in this environment relative to previous positions in hospitals abroad (Ibid). Hardhill and Macdonald's (2000) study discussed downward mobility experienced by newcomer nurses to the UK and Allan and Aggergard (2003) describe senses of frustration and loss of identity associated with no longer being allowed to practice clinical procedures that used to be routine in home countries (Ibid, also Nicholls and Campbell, 2007).

Broadening the scope of this literature survey to include sources on migrant workers more generally, many authors discuss employment challenges faced by non-natives. A persistent theme is that dimensions of race, gender, region/country of origin and their relation to broad societal perspectives in the new country structurally prevent migrants being allowed to begin working equitably with native workers. Datta et al (2007) observe that migrants to Europe 'are rarely the poorest of the poor and that they usually view migration as a conscious strategy to improve their lives'. Yet structural barriers including language (Mojab, 1999), non-transferability of qualifications (Green et al, 2007) or embedded knowledge (Williams, 2007), discrimination and prejudice, mean that many migrants working in low end

jobs must resort to mere coping-strategies in order to survive, at least at first (also Koert et al, 2007, Fuller, 2011, Akresh, 2008). Williams (2007) observes that unsatisfactory first jobs in new countries can function positively as 'stepping stones' during a period of acculturation, or negatively as 'entrapments', where underinvestment in training or language prevent workers from moving onwards and upwards. Kofman (2000) draws attention to a particular lacuna of research concerning skilled migrant women; neglected by both individualist focusses on the archetypal, unattached, rational male migrant and feminist attention to the most subordinated low-skilled migrant women. Whilst this study involved interviews with both male and female carers, the significantly higher number of women working in care (and represented within the sample) makes gender-awareness imperative in this research field.

Even within the closely defined focus on migrants working in residential care, it must be remembered that there is much heterogeneity. Intersectionality is an important concept in this context. McCall (2005) defines this term as 'the multiple dimensions and modalities of social relations and subject formations'. It emerged from feminist and post-colonial genealogies and racially-oriented employment studies (Crenshaw, 1989) and its multiple dimensions have been listed as gender, race, ethnicity, class and sexuality (Brah and Phoenix, 2004, Yuval-Davis, 2006). These modalities of identity are combined in a constellation of ways within individuals, and each can represent a dimension for which a person or group may be subordinated or excluded within society (Davis, 2008). Following Ferree (2010), it is valuable to add 'family role' to this list, as it in turn can describe a dimension which diversifies the identity formulation and subordination experiences of individuals (Doyle and Timonen, 2010 explore this with specific focus on migrant carers). Likewise, Doyle and Timonen (2009) and Wall and José (2004) highlight that country of origin exerts an important force on experiences in the new country; related to experiences of discrimination, culture shock, and continued connections with home (also Bevelander, 1999). In terms of citizenship status and civic freedoms, Kofman (2002) notes that European migratory flows are increasingly diverse and 'stratified', with the proliferation of different categories, statuses and indeed of temporary and undocumented migrants who are seeking work precariously (also McGregor, 2007). This means that migrants with identical qualifications might fare differently within the UK labour market depending on their official

(or unofficial) status. Finally, the fragmented UK care sector itself provides a diversity of work experiences, with the more closely regulated NHS anecdotally appearing preferable to the private sector (Allan & Aggergaard, 2003, Redfoot and Houser, 2005, McGregor, 2007). It is worthwhile to consider the narratives of migrants through the lenses of intersectionality in order to avoid essentialising any one experience.

3.2 Theoretical Models

3.2.1 Underemployment

Succinctly, Maynard and Feldman (2011:1) define underemployment as 'when workers are employed in jobs which are substandard relative to their goals or expectations'. In their comprehensive review article, McKee-Ryan and Harvey (2011) observe that underemployment is a multi-dimensional concept. They define the 'underemployed' as 'inadequately employed, underutilized, underpaid, overeducated, overskilled, and overqualified or as having low skill utilization or reemployment quality'. One of the original conceptualisers of the term, Feldman (1996), suggested a list of 19 hypotheses relating to the antecedents, characteristics and outcomes of underemployment. Appendix 1 illustrates these and details from other underemployment studies have been added by McKee-Ryan and Harvey (2011). These authors have collated an array of studies which have concerned different macro, meso and micro aspects of underemployment (see Appendix 2). This appendix highlights the micro-(individual) level theories of underemployment which will be tested and challenged with reference to migrant carers in this study. The existing propositions concerning the antecedents and consequences of underemployment provide the theoretical starting point for understanding 'causes and effects' of underemployment.

Feldman's (1996) hypotheses regarding the antecedents of underemployment suggest that underemployment is to be expected alongside economic recession, with some of the most vulnerable comprising those concentrated in industries in decline. Whilst the British care industry continues to sustain high demand, the highly privatised nature of the UK Care industry has left some homes exposed during the current financial crisis (*Western Morning News*, 2011). Feldman also suggests that potential ways to reduce individual vulnerability include retraining and geographical relocation in search of new, more appropriate work. Given that migrants have already undertaken geographical relocation, frequently motivated

by a strong work ethic, and often engage with retraining in order to gain employment, it is interesting that they nonetheless seem to experience increased levels of underemployment vis-à-vis the native population (Ibid, Datta et al, 2007). Fleetingly, Feldman (1996) notes that women (particularly mothers) and minorities are more likely to face underemployment due to structural barriers (also Slack and Jensen, 2004 and 2011, De Jong and Madamba, 2001). Attention to the gendered nature of underemployment is particularly relevant to analysis of an industry so dominated by female workers (Social Platform, 2010). To date there is only inconclusive or confounding evidence regarding the interaction of race, gender and education for the underemployed (McKee-Ryan and Harvey, 2011). There is much scope, therefore, to refine underemployment theory in order to make it relevant to the specific migrant carer experience.

Turning to the consequences of underemployment, Feldman (1996) invokes the stress literature in order to understand 'when underemployment energizes, rather than paralyzes'. He observes that workers might develop a range of coping strategies; potentially reducing the quantity or quality of their output in order to feel that their effort is matched by their remuneration or recognition. This again is an interesting suggestion in the context of care-giving where the 'output' impacts on the wellbeing of needy people. It should also be noted that migrants may not access welfare benefits when they carry work permits, making a strategy where one might risk losing a job unappealing. In a study of how migrant nurses deal with feelings of undervalue and disrespect, other researchers found that an alternative coping strategy was to constantly strive to exemplify best working practice (Allan and Aggergaard, 2003). Other research has posited that economically-motivated migrant workers have other outlets which could provide solace to balance the frustrations of their present working environment. These include sending remittances to family overseas, investing in property for enjoyment in their future lives and/or biding their time in unpleasant jobs while retraining for more aspired-to careers (Ibid, Doyle and Timonen, 2010, Datta et al, 2006, 2007, Schneider and Holman). The study of migrant coping strategies when faced with underemployment will therefore be intriguing; given its impact on the people they care for both professionally and personally. This study's focus on coping will be further explored in subsequent sections below.

3.2.2 Objectivity and Subjectivity in Underemployment Studies

Whilst it is vital to understand the antecedents and consequences of underemployment and consider them in the context of migrant working patterns (as explored above), this study will also concern the experience of underemployment itself. Returning to Appendix 1, this requires an understanding of the central box which presents objective and subjective dimensions of underemployment on a continuum. As McKee-Ryan and Harvey (2011) stress, underemployment is a notoriously slippery concept to define and has a strong subjective element (also Feldman, 1996). Underemployment is an inherently relative idea requiring the individual worker to compare themselves unfavourably to co-workers, contemporaries from their student days or home towns, managerial superiors, perceived inferiors or a personal measure of their own self-worth in order to reach the sense that they are underemployed. This personal thought process is itself forged by pre-existing ideas about hierarchy, job satisfaction and status in wider society (Maynard and Feldman, 2011). In these ways it is a deeply personal and subjective state and can result in a sense of relative deprivation if the desired standard is not reached (Crosby, 1984, Feldman et al, 2002). Furthermore, unlike 'unemployment' or 'job satisfaction', it is not a term that has established cache or connotations throughout society (Feldman and Turnley, 1995). As a result, people are not necessarily quick to identify their work status as one defined by underemployment. Researchers must therefore make sense of more nebulous narratives of employment trajectories and work experience by clearly teasing out and operationalizing multi-dimensional elements of underemployment in order to pin this sense down (McKee-Ryan and Harvey, 2011).

Several researchers have attempted to generate objective measures of the job characteristics which could cause a worker to be underemployed, often starting from an economics-based understanding of employment (focussing on pay, hours, productivity and human capital, Maynard and Feldman, 2011). McKee-Ryan and Harvey (2011) summarise these in Appendix 1. Feldman and Turnley (1995) would identify skill underutilization, overeducation or overqualification where an employee is working in a job which a) does not require a degree, b) is in a different field to their area of study or c) is unlikely to maximise their skills or training at present or in future. One can generate relatively objective scales to measure this, for example as in Quinn and Maldinovitch's (1975) study where aggregated

archival data was used to generate average number of years of education possessed by contemporaries and co-workers, and then compared with an individual's own educational history. Yet space for subjectivity quickly becomes apparent in judging this, especially on the part of the researcher. Khan and Morrow's study (1991) for example compared self-reports of education histories with the minimum level of education *perceived* necessary to qualify to fill the employee's position in an attempt to identify objective discrepancies. In the case of hours or pay underemployment, Feldman and Turnley (1995) note that researchers often require their subjects to compare their current hours/salary to a previous job in order to gauge underemployment, yet this measure is defunct in the case of certain demographic groups such as recent college graduates. Arguably this applies also to recent migrants who are likely to have last worked in incomparable job markets overseas. Furthermore, care work's recruitment strategy in this current period of high demand is, in itself, likely to predispose any employee who completed secondary school to objective overqualification as it is possible to begin working as a care assistant with no previous qualifications (McGregor, 2007).

These debates within the underemployment paradigm underline the necessity to retain attention to the subjective, behavioural element (Khan and Morrow, 1991). A useful concept in this instance is that of Person-Job fit (sometimes overlapping with measures of Work-Status congruence). These ideas state that positive work outcomes are most likely to occur when an employee's knowledge, abilities and characteristics match the demands and nature of their job (Kristof-Brown et al, 2005, Edwards, 1991). A discrepancy between these elements could be responsible for the negative work outcomes accompanying underemployment (McKee-Ryan and Harvey, 2011). Yet, it will be important to remember that there is no linear, dependable relationship between the supply and demand elements of working. Indeed, as Kokko and Guerrier's (1994) study of Finnish hotel receptionists found, 'just because an employee is technically overqualified for a job, there is no reason why she should necessarily feel that her skills are underutilized.' It will be interesting to see which dimensions of underemployment, if any, are reported within the caring profession.

3.2.3 Coping Strategies

Maynard and Feldman (2011) state simply that 'underemployment hurts'. It can have serious negative consequences both in the short- and long-term on job satisfaction, career success and personal wellbeing. In order to extend underemployment theory's understanding of how the underemployed cope with this (following Feldman and Turnley, 1995), this study will draw on another theoretical framework; Long et al (1992) and Folkman et al (1986)'s stress and coping research. These studies are compatible with the intersectionality awareness of this study outlined above. They anticipate that coping with occupational stress differs according to gender (Datta et al, 2007). They also give a high level of recognition to the agency of their research subjects in dealing with stressful events (Long et al, 1992). This is appropriate to studies of labour migrants who tend to be proactive; motivated to move country, maintain a job and further the prospects of themselves and their families (Datta et al, 2007). Furthermore, Long et al's (1992) development on Folkman et al's (1986) original theories of stress and coping maps compatibly onto Feldman's schema of underemployment. By identifying the cause of stress (antecedent), the process of deciding what coping strategy to use (experience) and combined effect of the stressful event and mediating coping approach (outcome), this theoretical framework compliments Feldman's model (Appendix 1).

Lazarus and Folkman (1984) define coping as 'a person's cognitive and behavioural efforts to manage demands that are appraised as taxing or as exceeding their resources' (as quoted in Long et al, 1992). These researchers have found that people tend to appraise a stressor according to 'what is at stake' and the problem's controllability (Folkman et al, 1986; Long et al, 1992). They are then likely to employ several coping strategies at once in order to mediate the stressor's effect on their lives, wellbeing, families or careers (Ibid). Folkman et al (1986) have identified a number of coping strategies that categorise a significant range of approaches reported by people across several studies. These are listed in Appendix 3. Further to this, Long et al (1992) have somewhat simplified the conceptualisation of coping strategies by grouping categories broadly into strategies of 'engagement' (e.g. problem-solving, active attempts to ameliorate perceived problems) and 'disengagement' (e.g. emotion-based processes of withdrawing from the 'stressor' in order to protect oneself). Folkman et al (1986) describe eight different coping strategies in detail and these can be translated or operationalized relatively simply into codes for analysing interview transcripts.

It is important to remember, however, that these labels were the outcome of Folkman et al (1986) and Long et al's (1992) quantitative survey based investigations. For this project, the broader, more interpretative thematic groupings of 'engagement' and 'disengagement' will be kept in mind as they are more versatile tools; useful in the processing qualitative of data.

3.3 Empirical Research Question & Sub Questions

In order to extend the literature presented above and develop a migrant-carer perspective on underemployment, the following research question has been formulated:
How do migrant workers become vulnerable to, experience and cope with feelings of underemployment in the UK care sector?
Four sub-questions have been formulated below, accompanied by twelve hypotheses (a - l).

1. **What are the antecedents of underemployment for the studied group?**

Feldman (1996) suggests that the following factors are micro-level antecedents of generalised underemployment; job type, demographic characteristics, career history, job search strategies, employee experience and traits, and personal work preferences (see Appendix 2). The hypotheses are that;

a) Migrant workers are likely to be subject to these same antecedents, but certain factors might have more effect than others and indeed external factors might play a role, for example;
b) Employee characteristics and traits (including reduced language proficiency, unfamiliarity with the UK system, introverted social networks) might make these workers less able to engage in comprehensive job-search strategies or to promote the value of their experience or career history (Williams, 2007).
c) Additional antecedents (e.g. gender-, family-role or race-based discrimination) might increase migrant underemployment, in turn constraining other antecedents, such as personal work preferences (Doyle and Timonen, 2011).

2. **Which elements of underemployment do migrant care workers describe?**

McKee-Ryan and Harvey (2011) note that underemployment has both objective and subjective forms and can encompass many dimensions of work including; pay, hours or hierarchy underemployment, work-status incongruence, overeducation, perceived

overqualification or skill underutilization and relative deprivation in comparison with others. Burris adds that limited opportunities to learn and 'grow' on the job can intensify a sense of underemployment (1983). Following Feldman et al (2002) the following hypotheses suggest causal links between underemployment antecedents and objective senses of underemployment but also the idea that subjective underemployment assessments can mediate underemployment outcomes. These combinations include;

d) *Skill & Career History*: Higher skilled workers or those with extensive work experience might describe objective skill-underutilization, hierarchy underemployment and/or overqualification. In contrast, lower-skilled workers or those first embarking on careers might describe hours underemployment and more subjective senses of relative deprivation instead (Datta et al, 2006).

e) *Sector*: Workers in public, private or charity sectors might describe different senses of underemployment depending on internal policies, culture or expectations (Redfoot & Houser, 2005). These policies might intensify feelings of objective underemployment (for example where acquiring qualifications or a certain amount of experience does not impact promotion prospects). Alternatively, internal policies might allow workers to feel subjective job satisfaction (for example where there is an open dialogue between workers and their superiors regarding changes to working practices and the opinions of carers are valued) and therefore disregard objective indicators that they might be underemployed.

f) *Work Status:* Particularly where workers feel they are employed at objectively low levels vis-à-vis other employees, perhaps due to racial discrimination, carers might describe objective hierarchical inequities, subjective work-status incongruence and relative deprivation (Allan and Aggeggard, 2003; McGregor, 2007).

g) *Null hypothesis:* Finally, however, following Kokko and Guerrier (1994), the possibility for falsification of underemployment theories' predicted connections between low-status jobs and an objectively overqualified workforce must be allowed for. Where care workers feel a vocation for their profession, they may not describe experiencing subjective underemployment at all.

3. What are the consequences of underemployment for these workers?

It was hypothesised following Feldman (1996) that;

h) Underemployment will have generally negative impacts on individual career trajectories, job attitudes, job-performance and employee turnover (intention to 'quit').
i) Furthermore, the underemployed will describe depressed psychological or physical well-being (McKee-Ryan and Harvey, 2011)[2].

4. How does this group cope with the sense of being underemployed?

To date, there is little anecdotal evidence of how carers manage the sense of being underemployed. In general, it is anticipated that individual carers will describe different strategies depending on their own predispositions. A few tentative suggestions are that:

j) Workers might adjust work performance to suit perceived low remuneration (Feldman, 1996) representing a 'disengagement strategy'. As noted in the literature section above, however, migrant workers have specific motivating factors for maintaining their jobs (related to visa requirements, supporting families in their home countries or aspirations for making a new life in the UK). It would be expected, therefore, that coping will be constrained by the migrants' personal and professional care responsibilities which make it difficult to reduce quality of working output.
k) *Alternatively*, workers might demonstrate exemplary professional experience in order to maintain pride in their professional abilities (Allan and Aggeggard, 2003) and pursue more 'engagement' strategies such as raising problem issues with bosses or clients (assuming that these workplaces are receptive to hearing grievances which is not always the case, Williams, forthcoming).
l) *Alternatively*, engagement and disengagement strategies might be used in combination (Long et al, 1992) to maintain the emotional wherewithal to carry out care work. Efforts could potentially include retraining and renewed job searches or more internal processes of altering personal aspirations, planning to return to home countries or finding self-worth outside of the workplace.

The following chapter will describe the research methodology in which these themes were collated, analysed and examined in order to build up pictures of migrant carers' negotiation of underemployment.

[2] Given the sensitive element of these domains participants were allowed to dictate the particular consequences that they felt comfortable mentioning in their narratives(following Doyle and Timonen, 2011, Elliott, 2005).

4.0 Research Design

4.1 Methodology

The sparse nature of existing literature on the subject of migrants' experience of underemployment whilst working in the care sector makes an exploratory, small-scale, qualitative study of the issue appropriate. The chosen approach for this research was to undertake in-depth interviews with a diverse sample of migrant care workers and use qualitative methods to draw out observations and themes.

In order to gain an explorative insight on 'migrant care worker experiences' a relatively representative approach was taken, attempting to collect interviews across the range of institutional and ethnic configurations of care work. Interviewees were selected from public, private and voluntary care settings. Participants were also recruited from the three different regional backgrounds which are predominantly represented in British care homes; South-East Asians (9), Africans (5) and Eastern Europeans (6) (reflecting Cangiano et al's 2009b care workforce figures). A total of eleven different nationalities[3] were represented. Of these there were fourteen women and six men. Their ages ranged from 22 to 58 with the majority clustered in their 30's and 40's. They had spent between one and 40 years in the UK, with the average being almost 11 years. See Appendix 4 for a summary table of the interviewees.

These participants were accessed through a range of approaches, each of which yielded an approximately equal number of interviewees. The approaches included;

- An open invite to any eligible migrant care worker was placed on an online immigration blog which has a good reputation within the UK for its credible covering of policy issues related to migrant carers and a high readership[4].
- Ethnicity based community organisations (e.g. Philippino Associations, Polish Federations) were asked to invite any care worker members to participate.
- Care home managers were contacted directly, encouraged to display information posters about the study and invite their employees to participate; an approach which Cangiano et al (2009a) found successful.

[3] Philippines, Malaysia, China, India, Nepal, Nigeria, Ghana, Zimbabwe, Sierra Leone, Poland and Romania
[4] http://www.immigrationmatters.co.uk/calling-all-foreign-born-care-workers.html Accessed 23.06.2012

- A public service trade union also encouraged their members to participate.

The potential for 'gatekeeper influence' must be acknowledged in these latter two approaches as managers and union officials might not wish to expose their operations to critical scrutiny, not least at a time when care-home scandals have the potential to close institutions (*The Guardian*, August 2011). In these cases, participants might feel the pressure to say 'what their bosses would like them to say', although all reassured the researcher that it was their free choice to participate (Atkinson and Flint, 2001). In order to mitigate this, participants and managers beforehand were informed that all parties will be kept anonymous. Finally, after gaining initial access to the first interviewees, a snowball approach was taken, tapping into migrant social networks in order to access representatives from all three ethnic groups, again in order to minimise the influence of managers (Ibid). Twenty interviewees was a practical number of interviews to undertake in the time allowed and primary research stopped once theoretical saturation was acquired.

It must be noted that gaining initial access through any of the channels was a time-consuming process. Two months elapsed between the first approaches and the first interview. During this time many care homes decided not to take part, unions disseminated the information bit by bit through their networks and the trust of community organisations and individuals was gradually gained. Upon reflection, the most effective way of inviting participants to interview was through the online blog post. This cut out gatekeepers and ensured that individuals made the personal and practical decision to participate. Community organisations also (when they had strong existing information sharing networks and close working relations) greatly encouraged members to participate without pushing an additional agenda. Gaining the trust of leaders in these organisations was, however, vital in order to gain this access and necessitated a significant time investment. Contact with unions functioned in a similar way, however, as union officials tended to have a large existing workload, few union networks were able to effectively inform members about the study and encourage interviewees to take time out of their non-work hours. Recruiting participants through care home managers was least effective. Informative letters, e-mails and follow up phone-calls were sent to approximately 50 care home managers in a wide area. The commonest reasons cited for not promoting the study within their care homes were that they were 'too busy', 'saturated with research requests' or simply disinterested.

Where managers did publicise the study but did not forward on prospective participants, the feedback was that their staff did not have enough free time. Eventually, a decision was taken to offer £10 gift vouchers in return for giving an interview. Many interviewees noted that this was not their main motivation for participating, but this offer did coincide with an increased participation in the study and perhaps ensured that certain interviewees felt more positive about nominating friends for snowball sampling.

Self-selection is a strong bias in this sample. Regardless of the approach, almost all the interview participants had a confident grasp of English and were comfortable speaking with an unknown British researcher (for exceptions see Appendix 4). The sample is unlikely to be representative of the wider migrant caring workforce in the UK, especially recent arrivals. Indeed, as Appendix 4 indicates, several of the carers had been in the UK for decades. Appendix 4 also shows a skew in the sample towards migrants from the Philippines and Poland. This reflects the high presence of carers from these locations following both historical recruitment strategies and recent trends (Cangiano et al, 2009b), but also the snowball technique which tapped into strong networks in these communities early on in the primary research phase. Subsequently relatively few interviewees could be accessed from African backgrounds and unfortunately there are no representatives from the Caribbean, despite their significant presence in British caring jobs. The interviews were conducted across the UK and have a wide geographical spread, albeit located predominantly in (sub)urban locations. As snowball sampling rarely nominated contacts working in the same care home as the initial interviewee, very few of the participants work in the same place and the sample described experiences from a wide range of different care homes in the UK (except those within the charity sector who all worked in a single institution).

The interviews were recorded and transcribed once informed consent was granted from the interviewee (See Appendix 5). The interviews themselves were semi-structured, encouraging life-narratives to emerge by asking the interviewees to describe a historical trajectory of their education and migration story. All interviewees were presented at first with a simple diagram (Appendix 6) highlighting the three main themes of the study in order to help them focus on their relevant experiences. The diagram is deliberately simple in order to overcome language-barrier misunderstandings that might have existed before the

interview and also so as not to influence respondents' answers with too structured an approach. Prompting, open questions explored how they perceive their work arrangements and how they cope with arising frustrations (See Appendix 7). The initial interviews were used as pilots, and after their completion, the interview scheme was reviewed; questions were rephrased to make them easier to understand and additional probing questions were added. Hoggart et al (2002:209) observe that a semi-structured approach can establish a relaxed rapport between interviewer and interviewee and this encouraged confidence and candidness. Elliot (2005) encourages the use of narratives in interviewing as they empower the respondents – something that was deemed important in order to balance potential power imbalances between interviewer and interviewee. Furthermore, as noted above, diverse influences in a person's life can lead to their employment and migration decisions (including family, personal ambition, training experiences etc., Wall and José, 2004, Datta et al, 2007). Elliot (2005:31) observes that 'by moving backwards and forwards between the different areas of the respondent's life, the memory is stimulated', and it was hoped, therefore, that encouraging narratives to emerge might produce a rounded, holistic impression of these personal decisions with a high level of qualitative validity.

Once typed, the transcripts were then closely read in order to develop a 'rapport' with the material (Peace, 2000). In order to conduct systematic coding and analysis and reduce researcher discretionary bias (DeWalt and DeWalt, 2002), a qualitative data analysing programme was used. MaxQDA10 software was selected after a trial of several programmes for its manageable learning curve. The coding system operationalized in Table 1 below was then applied across the twenty transcripts involving more re-reading. Once coded, MaxQDA's tools enabled links between themes to be visualised, tested and understood. The findings from this exercise will be detailed in the following chapter.

4.2 Operationalization of codes

In order to test the hypotheses and draw out dimensions of underemployment reported by the sample, a list of codes was formulated. These initially comprised terms from McKee-Ryan and Harvey's schema of underemployment (Appendix 1), as well as Folkman et al's engagement and disengagement coping strategies (Appendix 3). It should be noted, that the interpretation of these code names has been tailored to the study of migrant workers, so

the operationalization of the themes differ somewhat from McKee-Ryan and Harvey's original. These were added to using themes discovered in the theoretical exploration above. During the analysis phase itself, yet more codes were added when themes emerged inherently from the interviews (these are marked with a * in Table 1). These code names represent tags simply for categorising themes emerging in the transcripts. This stands in contrast to the meaning they have been ascribed in the theories discussed above where a causal link is already implied.

Table 1 Code Operationalization

Code	Sub-codes	Operationalization and notes
Intersectionality/* Demographic Characteristics	Gender	Male or Female
	Family role	Parenting or caring for a family member or not.
	Ethnicity	African, South-East Asian, European
	Nationality	Country of Origin
	Age	In years
	Time in UK	In years
	Care Sector	Public, Private or Charity.
Antecedents	Career History	Observations of work experience and expertise/education; describing upwards/downwards/plateauing trajectories; being made redundant. Also includes job-type (i.e. managerial, team leader or assistant) in order to ascertain status and status-change.
	Employee Experience and Characteristics	A more nuanced code than the factual demographic characteristics above. Observations on English-language proficiency and familiarity with British work and social norms, as well as expectations brought from home and general work ethic. A specific sub-code of 'Initial unfamiliarity*' was added as this was a prominent emerging theme in this strand.
	Job Search Strategies	Includes any information about securing and beginning care work in the UK.
	Personal Work Preferences	Includes, for example, wanting more or less responsibility, wanting more/fewer/day/night shifts, working with more/less challenging clients, balancing work-family life
	Training Opportunities	Any examples and opinions on training offered by the employer and/or undertaken by the interviewee (another code below notes whether this is used as a coping strategy or is a simply mandatory element of the job).
	Discrimination*	Any examples of discrimination which the interviewee identifies as limiting their personal ability to escape underemployment. Can be racial or gender-based.

Code	Sub-codes	Operationalization and notes
Objective Underemployment	Pay/hierarchical underemployment	Receiving less pay or fewer promotion opportunities than others (including co-workers or peers). A specific sub-code was added to highlight comparisons with pay in home country*.
	Hours underemployment	Not being offered sufficient hours (as deemed by interviewee).
	Overeducation	Having training and expertise far exceeding minimum entry requirements for care jobs (i.e. above secondary education for care assistants, NVQ level 4 for managers).
Subjective Underemployment	Person-Job congruence	Observations on (in)congruence between individual personal qualities and the demands of the job.
	Perceived Skill Underutilization	Considering themselves to have better qualifications and skills than co-workers, or working in an inferior job relative to other peers.
	Relative Deprivation	Feeling disadvantaged relative to co-workers or other social contemporaries for a defined reason, and that they deserve better. Expresses a sense of inequity and, perhaps blame.
Outcomes	Job Attitude & Performance	Any observation related to job attitude (such as job satisfaction, work alienation or work commitment) particularly in connection to expressed feelings of underemployment. A sub-code was added including observations on the level of professional performance* delivered in spite of feelings of underemployment.
	Career Outcomes	Observations on career trajectories going up, down or plateauing as a result of their care work experience and perceived future potential career directions.
	Intention to quit	Statements referring to quitting as a remedy to feelings of underemployment.
	Personal wellbeing	Any observations of the effect of work on their personal wellbeing, in particular related to feelings of underemployment.
	Underemployment rejected*	A subjective sense of underemployment is not reported and is in fact rejected (proving the null hypothesis).
Coping*	Intention to retrain*	Statements referring to training more or in a different field in order to overcome sense of underemployment.
	Engagement	Confrontation, seeking social support, taking responsibility or planful problem-solving (See Appendix 3 for more detailed operationalization, following Folkman et al).
	Disengagement	Distancing, self-control, escape-avoidance, positive reappraisal (See Appendix 3 for more detail). An 'Other Outlets'* subcode was also added as this was related to the experience of belonging to a migrant community. 'Humour'* was also added as a subcode, an inductive theme in the transcripts.
	Team-based strategies*	Observations on teamwork and management style as external coping aides.

4.3 Scientific & Social Relevance

It is important to explore the issue of underemployment amongst migrant workers in the context of a wider UK agenda for skills, economic growth, and labour maximisation (Williams, 2007; Rubin et al, 2008). Migrant care workers are enabling the native workforce,

and women in particular, to become economically productive and the quality of the care they provide is vital to modernising care and gender regimes (Ibid). From a deeply ethical perspective, Rubin et al (2008) note that 'the protection of domestic and care workers and the provision of security and benefits are crucial to ensure that the economic and social successes of some are not built on inequalities and on exploitation of others'. For these reasons, these explorations could contribute to a more detailed understanding of the current environment of care and the scope that social policy can have in raising the quality of jobs in the care sector for the benefit care givers and care receivers alike (Ungerson, 2004). In these ways, this study should have relevance to the social sciences and to policy-formulation.

More specifically, the study's bringing-together of previously siloed strands of literature should represent a novel and focussed appraisal of the phenomenon of underemployment within a closely defined demographic. The research should fill in some existing gaps in both underemployment and migration studies such as extending Feldman's 'antecedents and consequences' conceptualisation of underemployment by adding a 'coping strategies' element. It is hoped that this introduces a pragmatic and applied component into the study of underemployment and migrant carers.

4.4 Interdisciplinary character of the research

As McKee-Ryan and Harvey (2011) and Feldman (1996) suggest, the topic of underemployment concerns economists, managers, sociologists and psychologists alike. This is due to its implications for efficient human resource management, human capital maximisation and the study of social or behavioural phenomena. Focussing the study on the specific experiences of migrants and maintaining a gender awareness has the potential to further interest geographers, political scientists and historians whose individual research interests might span post-colonialism, feminism, development and/or demographics (Blunt, 2007; Willis and Yeoh, 2000, Winkler, 1999; Yeates, 2004, 2005). The richness of this field also has much to offer the formulation of social policy. As the problem construction above outlines, concerns about migration and care provision in the UK are increasingly interlinked; policy-making must therefore be interdisciplinary in order to ensure that developments in one domain do not jeopardise the other (Doyle & Timonen, 2011).

5.0 Results

In answer to the central research question and its four sub-questions this section will present the findings and observations from the twenty interviews. It will describe elements of underemployment theory which the interviewees saw as relevant to them, add new insights and challenge the existing precepts where they were deemed inapplicable.

5.1 Underemployment Antecedents for Migrant Carers

5.1.1 Career History, Job type & Job Search Strategies

Feldman's original propositions (1996, Appendix 2) stated that individuals are more prone to underemployment for the following reasons; they have been unemployed or career plateaued prior to their present job; they are managers; or their job search was prolonged, of low intensity or resisted geographical relocation. Descriptions of career history from the sample rejected some of these assertions. A large majority of the interviewees had entered the UK on work permits and the others had held student visas, relative/spouse visas or asylum seeker status when they arrived. In all cases, they needed to ensure they could support themselves independently having relocated away from family and social support networks in their home countries. Although two of the Eastern Europeans remarked that it was easier to get a job in the UK rather than at home, because of national economic factors, none had been unemployed before making their migration. Indeed, most had been on an upward career trajectory. José, for example, had become Head Nurse of an Accident & Emergency Department in the Philippines and Ishayu was gaining profile in his Nepalese company as a medical inspector supervising twenty-nine subordinates. Those who had been unsure which career path to take and could perhaps be described as career plateaued (such as Paul who had worked within his family's business for approximately a decade since leaving school in Nigeria) were more likely to have entered on student visas with the aim of becoming qualified and raising their employment prospects in their desired employment field.

In terms of job type, the inverse of Feldman's proposition was found. Of the six interviewees who had managerial responsibilities, all reported lower levels of subjective

underemployment and better job satisfaction than those with a lower Care Assistant job title. In a sector where the Care Quality Commission (CQC) increasingly demands that the activities of front-line carers are tightly documented and regulated, several managers and senior carers such as Irina and Safiah relished the greater autonomy, freedom to dictate their own professional approach and respect that their higher position afforded them. The opposite sentiment was frequently expressed by those lower down the hierarchy.

Finally, in terms of job search, several participants described strategies which depart from non-migrant scenarios upon which Feldman (1996) based his assumptions. Several participants in this study described instances where their influence on job search was severely limited by their migrant status. This ranged from being reliant on agencies for arranging work placements in the UK to seeking the first job offer possible in order to escape dire circumstances. Joseph, for example, described lasting back injuries from working in a care home for four months where there was insufficient health and safety provision for the staff. The following describes his difficulties searching for a new job;

> *'during my application for change of status I did not say anything to the manager because they might block it. We were told by the management, I can call immigration to cancel your status and that is worrying… 'if you are not working here anymore your visa will be considered invalid'. So while I am working, it is very tough I am feeling the pressure is too much, working very hard, applying for your visa, spending a lot of money, and that four months was really just hell' Joseph, 39, Philippino, Care Assistant, Private Sector, London*

Happily in this case, Joseph was able subsequently to secure a job which was less physically demanding and which applied his computer, administrative and caring skills. Ishayu's job-search, however, was also frantic and shadowed by immigration challenges, yet it resulted in a placement in an isolated care home with substandard worker accommodation. Having arrived in the UK with a student visa to study Health and Social Care at a college which had had its license revoked since taking his fees, he waited six months before immigration authorities released his passport (necessary for acquiring both a place at a new college and a work placement). Having exhausted personal funds in this time, Ishayu describes his job-search at that time in the following way;

> *'At the beginning it was really frustrating. If you are hungry, you don't care what food is in front of you,... You just try to fulfil your hunger. That was me… If you can't do it, you*

don't have a choice, you can't refuse it. Do you have a choice to go for the good job? No, I don't have a choice at all'. Ishayu, 31, Nepali, Care Assistant, Private Sector, Hampshire.

Short, intense job searches like these characterised several narratives on this theme, with different outcomes regarding a resulting sense of underemployment. The majority of carers whose placements had been arranged by agencies or colleges experienced some feelings of underemployment, which may be expected given their relative lack of autonomy in the process, and the fact that only their capacity to care (and not other skills or work experience) was considered. Only a few interviewees described a more prolonged job-search. Most acknowledged that it was not difficult to get work in care homes, due to the high demand and turnover. Indeed, Irina, Dan and Emerson eventually took their first care jobs as 'a last possibility'; the result of being unable to secure jobs in another desired job-field. Their ultimate acquiescence that 'any job is better than no job' epitomises the state of being underemployed; although they were glad to be working, many stated that it was challenging to find care jobs where they felt sufficiently valued, respected and with promotion potential.

5.1.2 Worker Characteristics and Preferences

Unsurprisingly perhaps, a major influence on the starting level of almost all migrants' first job in the UK was the characteristic of English proficiency and/or familiarity with regional accents. Indeed, both Sharon and Maria observed that they did not want to go into a clinical setting on a par with their level in the Philippines because they first wanted to get acquainted with 'the lingo'. Arlene commented that her unfamiliarity with English and job applications meant that she couldn't 'do my CVs properly'. Gosia and Irina, who have both achieved career progression in the short time since moving to the UK attribute this to quick mastering of English, whilst others, such as Alicja, see it as the one thing holding them back from reaching management status and shedding her feelings of skill underutilization and hierarchical underemployment. Dan, who previously worked at a high level in the Indian shipping industry, attributes his failure to find even an apprentice level job in the British shipping sector due to a lack of familiarity with British shipping policy and practice. Poor English proficiency was thus a significant barrier to beginning work at a level which objectively reflected worker expertise in their desired job field.

It is important to retain a holistic view of the antecedents to an individual's underemployment. Several interviewees who were objectively underemployed on the basis of overqualification or hierarchical position nonetheless noted that they were relatively content to continue working in that way because it allowed them to maintain a stable personal life. Gosia, Clara, Alicja and Dan all commented that minimising a commute was a priority for them over job quality so that they could make the most of their non-work time. A shortened commute is especially appealing at the start and end of caring shifts which are typically twelve hours long. Sharon and José, both of whom desired changing to hospital setting in order to maintain a wide range of clinical skills, remained in their caring jobs for the time being as it allowed them to organise childcare effectively with their partner.

Furthermore, certain interviewees who already had some managerial responsibility (e.g. Dan, Sharon, Clara and Irina) or had had that status previously in their careers (e.g. José) said that they had the potential and sometimes even the opportunity for promotion higher grade, but rejected it to avoid the 'headache' of managing a care home. Yet others (including Safiah, Maria and Gina) objected to the perceived lack of meritocracy that governed promotions in their institution; they commented that they would not want to be promoted in the first place if it involved 'crawling' or becoming 'pally' with management rather than recognition of their skills.

5.1.3 Discrimination & Intersectionality

This final point ushers in acknowledgement of the significant role of discrimination in the antecedents of underemployment among migrants (Slack and Jensen, 2011). The most structural way that this manifests itself is in the lack of acknowledgement of foreign qualifications. Arlene noted, for example, that she was trained in the Philippines as a midwife, but as this was not recognised in the UK she has since been unable to work in her desired healthcare field. For Safiah, discrimination on the basis of her background threatened to jeopardise becoming qualified in the UK in the 1970's;

> *'The three year (course) allowed you to be a registered staff nurse and a ward sister and that gives you progression. With the two year training, you were treated as if you were stupid. And because I was a foreigner, I was even more stupid than the rest. I had a*

standard grade in tropical diseases, I know what happens to malaria, but they would speak to you as if you know nothing. It was a coded message because you go to the ward and they say 'Oh, that's a CCM, or CSI' and no one explains it to you, and it then became a coded message to exclude you' Safiah, 58, Malaysian, Project Lead, NHS, Glasgow

Others such as An and Ishayu faced challenges gaining qualifications and work placements as they were exploited by unscrupulous educational establishments looking to defraud foreign healthcare workers seeking respected British qualifications.

Barriers to career progression on the basis of gender or family role was noted by several women with children. Alenka, for example, noted that it had been difficult to regain her senior carer position since maternity leave six years previously. Concurrently, a number of male carers observed that their gender prevented them from becoming promoted or maximising their training in this highly feminized industry. Paul felt that, as an African male, he was frequently rejected by female care-recipients, even when he was simply changing dressings on hands or feet. The Eastern European interviewees commented that they felt less subjected to racist discrimination than their non-white colleagues. Clara, in contrast, described her first day in a Deputy Manager post where her supervisor gave her basic training only - far below her skill level, having qualified as a Community Nurse and worked for the Ministry of Health in Zimbabwe. This was on the assumption that, being foreign, she could not hold that position. Finally, Maria, who had almost twenty years of experience observed that, whether in the private or public sector, she had practically 'zilch chance of promotion' in contrast to her recently graduated Scottish colleagues.

On reflection, these findings support hypotheses a-c and nuance Feldman's (1996) original propositions for the antecedents of underemployment. Migrants indeed face similar antecedents to their British counterparts, but their racial and sometimes gender characteristics predispose them to challenges which are not faced by local people; whether this is initial unfamiliarity with language, constraints introduced by visa-related protocol, lack of recognition of foreign accreditation or blatant racism blocking recognition of their skills or experience.

5.2 Objective & Subjective Underemployment Experiences

5.2.1 Hours & Wages

Two objective indicators of underemployment – few hours and relatively low pay – were generally deemed by the respondents to be inapplicable measures in the case of caring jobs. Hours underemployment, whereby employees must involuntarily work part-time or fewer hours than desired, was practically non-existent. Indeed, carers reported working a minimum of 36 hours a week divided into gruelling 12-hour shifts, up to five 12-hour shifts a week, and in one case, in excess of 80-90 hours. A more frequent frustration was a lack of input or consultation on when these were scheduled and rapid transitions from night to day shift.

Regarding pay, most carers stated that they were not there to just 'take the money and go' (Gina); they would not stay in this line of work were it not for a commitment to caring as a career. Individuals who had worked in different sectors before, including private enterprise, shipping, private schools, construction or engineering remarked that the money could not be the main motivation, not least because as a public service it is challenging to generate large profits. Furthermore, the question of comparing pay to the carers' previous job becomes confounded in the case of migrant workers as almost all stated that the pay was significantly higher than they could have earned at home in a higher status job.

Nonetheless, there was sufficient range across different care sectors and within institutional hierarchies to make many of the lower-level carers feel deep inequity in terms of pay. In general, nurses in NHS elderly care facilities earned approximately £13.50/hour. Staff in the charity sector were paid minimum wage (£6.08/hour), rising to £10 for managers, which they acquiesced was necessary in a non-for-profit organisation. In the private sector Joseph described being paid around £5/hour and Asa referred to her agency employers as 'thieves' for taking a 50% share of her pay and leaving her with £6 - £6.50 per hour – a wage she deemed appropriate for 'kitchen porters' rather than carers who regularly save the lives of their clients. Alicja joked about 'doing voluntary work' as her wages were 'literally rubbish';

> *'It looks like nobody really appreciates what you are doing. Which is really very bad because sometimes when I am working on my clients I am thinking, come on, we are*

really doing a good job. Everyone is using their whole abilities, all their talents, everything to help them, and at the end of the day you are taking home £1000, you know, in London? Come on, this is unbelievable' Alicja, 38, Polish, Support Worker, Private, London

Another finding was that pay did not necessarily rise as carers were given more clinical or managerial responsibility. Clara, who has been steadily promoted throughout her career has seen her salary reduce from £17/hour to £15.34/hour since beginning work in the UK eleven years ago. For Gina, the biggest frustration was the fact that her own personal investment in phlebotomy training was not met with a pay rise, despite being the only worker in her grade with these new skills and being asked to take on significant clinical responsibilities and longer hours as a result;

I've been trained to do the [new] things, I've done very well, I'm proud of myself, but I'm not proud because they don't pay the work. Like I said, I don't need to pay extra money I don't know for what, just pay for my real work, for my real hours, for my real job, for my real hard work that I'm doing.' Gina, 43, Romanian, Care Assistant, Private Sector, London

5.2.2 Overeducation & Skill Underutilization

Turning to the objective measures of overeducation or overqualification, many carers described gaps between their human capital investments, capabilities and the recognition this received at work. Several members of the sample held bachelors and masters degrees ranging from Nursing and Human Anatomy to Theology, Business Administration, Computer Applications and Management Studies. Where their existing expertise lay in an unrelated job-field (such as engineering or shipping), carers tended to feel less frustrated by their relatively low position in caring hierarchies. This applied in Dan and Emerson's cases, where both had been offered investment in their new skills-set, granted promotion opportunities and reported job satisfaction.

In contrast, several carers who were trained nurses or who had management experience felt that their skills were underutilised. There was mixed reporting of to what extent foreign qualifications were recognised; Clara's Zimbabwean qualifications for example were immediately valid in the UK, whereas Arlene's midwifery training was not. This tended to vary based on when the migrant first arrived in the UK and their qualifications' comparability with UK standards. Within the sample's Philippino nurses, however, wide

discrepancies in the time it took to complete acclimatisation were reported – from 6 months to 6 years, despite all having worked at similar grades previously. This suggests poor dissemination of information to these nurses about how to gain British accreditation.

Tension arose particularly where carers were asked to do non-clinical tasks such as laundry, making tea and washing the floors. Maria felt 'belittled and degraded' by these requests which she would never have been asked to do in the Philippines and which were rarely asked of non-migrant colleagues. Arlene and Asa felt that as care assistants they were 'just there to do the physical work'. Safiah reflected that 'a lot of the families who pay you to do this don't actually conceptualise it as work', instead, they see carers as 'angels' rather than skilled professionals. These perceptions of carers as unskilled workers was deemed to be relatively pervasive throughout wider society so that several carers, including Clara, Maria and Gosia, felt their knowledge was undermined regularly by managers, families and doctors. This manifested itself when there was a dispute over what was in the best interests of the elderly patient and the educated opinions of the carer tended to be overruled. Those with management experience such as Ishayu and Gina were particularly discouraged by the unreceptive responses of their managers to suggestions about improving task-sharing, teamworking or when reporting the sub-standard and sometimes abusive practices of co-workers. Both professed a strong desire to utilise their managerial qualificiations and also a professional loyalty to their superiors, yet both had been told to 'keep your mouth shut' about such observations.

Some anecdotes from those who had arrived as students, perhaps also at a younger age without an established career history (such as Gosia and Asa), suggest that senses of underemployment are less prevalent at this stage of life and qualification. Whilst they still described instances of unsatisfactory work, both also felt they were at the beginning of careers in this sector, for which they had a personal vocation, with much still to learn.

5.2.3 Relative Deprivation

Value-based judgements on hierarchies of work and subjective underemployment emanated from a number of sources. Migrant carers had to contend with expectations from home cultures, families, British society and their own value systems, and sometimes these

conspired to make carers feel deeply underemployed. This sense of under-achievement and low-status tended to be most keenly felt in the early years of a migrant's time in the UK when they first started care work. For Paul and Emerson, care work had deeply gendered connotations in their home countries of Nigeria and Sierra Leone and they refrained from telling relatives about the 'woman's work' they were doing in the UK. Asa noted that she received judgement from fellow Nigerians who she attends church with in London who think caring is a 'dirty job', even though she herself takes pride in how 'neat and fresh' she is at work. Gosia and Alicja were confronted by disparaging remarks from relatives at home who perceive care work as low hierarchically, as Alicja describes:

> *'it's really not so easy, it's not the job that people think it is. But also, I'm not ashamed of what I am doing because I like it, and I think this is really a privilege to do something like that because you are so deep involved in someone's life ... But my friend's father said to me 'Oh is this why you finished one university and then another … to go and wash shit now, is that it?' Alicja, 38, Polish, Support Worker, Private Sector, London*

For Ishayu and Joseph, comparisons with home were internalised into comparing themselves with peers from school or university. Ishayu felt 'embarrassed' and that he was 'wasting his life' in the slow process of achieving NVQs in Health and Social Care compared to peers who already had masters degrees.

Within the UK some carers felt they had 'carer, written on my forehead' (Gina), and this meant they were not valued in society. José felt that he was only respected when wearing his nursing uniform, but otherwise they see only the colour of his skin and 'they'll think I'm an asylum seeker' – which he felt is associated negatively with claiming benefits. The African and South-East Asian carers also regularly had to contend with racism and prejudice amongst the elderly patients in their care, which had the potential to weaken worker morale (Maria). Afua and Asa rationalised this, however, as a symptom of dementia which demanded a professional response such as altering medication patterns and this reappraisal of the situation allowed them to cope.

Aside from these demoralising encounters, racism at work had the potential to damage long-term career prospects where managers or co-workers held such views. Not only did several carers feel that their chances of promotion were inequitable compared to non-

migrant colleagues, but several carers described being suspended on false accusations of misconduct. They attributed these to racist colleagues and the assumption from managers that migrants were more likely to behave in this way. Maria was suspended for several months on basic pay and struggled to gain assistance from her union representative before eventually being acquitted of hitting a male resident with violent dementia. She subsequently faced difficulties finding new work as the managers mentioned the suspension in her references. José faced similar threats which never materialised. As a self-defence mechanism, he, Joseph and Dan all commented that they feel the need to always have a witness to their interactions with patients in order to avoid future false accusations, preferably another white carer, who they deem more credible with the management. Clara and Gina resented the increased surveillance and distrust of migrant workers which undermined their sense of professional status.

Finally, it must be noted that there were no instances of person-job incongruence. This might be a feature of sampling as the majority of the carers interviewed had remained in their jobs for several years, in spite of its many challenges. Alicja was of the opinion that ‘not everyone can do this job’, and if you cannot, you are unlikely to last very long (also Ishayu). Instead, most of the carers observed that they had high congruence with the demands of the job; describing themselves as patient, strong and naturally caring. They expressed satisfaction regarding working with people and making a difference at an important time in someone’s life, perhaps in place of absent family members.

From this section and in answer to sub-question 2), it is clear that migrant carers describe a multitude of objective and subjective underemployment experiences. It was found, nonetheless, that the nature of care work precludes hours underemployment and person-job incongruence. As predicted in hypothesis d), the career history and existing expertise of migrants is likely to impact on how overqualified, underutilized or hierarchically underemployed they feel, although this is predominantly where they worked in a care-related field before or had managerial responsibilities previously. In support of hypothesis f), discrimination was found to have a significant intensifying effect on feelings of hierarchical underemployment and senses of relative deprivation. This finding highlights an

external, societal antecedent of underemployment which affects migrant workers in particular and which has not so far been included in underemployment schemas.

5.3 Underemployment Outcomes for Migrant Carers

5.3.1 Career Outcomes

A central proposition in McKee-Ryan and Harvey's (2011) theoretical review is that underemployment is likely to 'dampen[] the overall career trajectory of individuals'. Whilst the interviews in this study collected a 'snapshot' of the carers' career progression, rather than a panoramic trajectory, the data reveals a diversity of outcomes on this point. Several carers noted, like Williams (2007), that they thought their entry-level caring jobs would be 'stepping stones' into more fulfilling or better paid work in the UK. For Sharon, Maria, José and Arlene, it was hoped that care work would allow them to progress into more clinical, hospitalised settings, following the statutory period of acclimatisation and personal adjustments to the language and working style. Joseph and Dan had hoped to make the transition eventually into work in other industries in the UK. Very few, however, have managed to make this transition[5]. Arlene, for example, has worked consistently as a Care Assistant for almost 30 years, despite wanting to become a midwife. As discussed above, some interviewees were constrained from taking the perceived risk of switching sector due to childcare commitments and others felt their English had not improved sufficiently for that step. Joseph, who had previously worked as a model, nurse, and in IT, and liked having different careers, articulated a sense of 'entrapment' (to use Williams' term) in the following way;

> *'if I want to change my career, it is so difficult… because your experience is not connected. If you want to work, for example, in a hotel, an office or in restaurant. Your experience is in the care, it's very hard to make the shift' Joseph, 39, Philippino, Private sector, London*

Migrants whose narratives challenge this causal link between underemployment and depressed career outcomes tend to be those who anticipate returning to their home countries. They see the potential to capitalise career-wise on the favourable exchange rate of their experience and qualifications gained the 'developed West'. Clara's story illustrates

[5] Admittedly this may be a factor of the sampling technique which only recruited migrants still working in care, and not those from other sectors who had made a transition out of the sector.

this trend as the only member of the sample who has undertaken two separate migrations to the UK. She worked initially as a nurse in the 1970's before returning to Zimbabwe until 2001. In the intervening period she was promoted from district nurse to Ministry of Health official and only returned to the UK due to political instability. Ishayu was also planning to return to Nepal after gaining a post-graduate qualification in Health and Social Care. He knows of only one other Nepali who has gained this degree and he now manages a specialist private hospital; success which Ishayu intends to emulate. Julita noted that the English which she has learned alongside caring will help her in her future studies back in Poland and a hoped-for career as an entrepreneur.

5.3.2 Job Outcomes

Feldman predicted that those who feel underemployed are more likely to have poorer job attitudes, lower work motivation, commitment and job performance. There were no reported personal incidents of employees reducing the quality of their job performance as a response to feeling undervalued at work within the sample[6]. Anecdotally, however, Safiah noted that frustrations of care work, related to a sense of undervalue and powerlessness could produce poor or even abusive job behaviour amongst some carers;

> *'your only ability to influence is probably a power relation with your patient. 'I can tell you when you can have tea. I can come when I want to'. That's the only power assertion that they have. And that's why, when we talk to care workers, they don't realise how powerful they actually are. It almost then could become an abusive relationship'. Safiah, 58, Malaysian, NHS Team Leader, Glasgow*

Self-reporting bias aside, the finding in this sample that carers generally do not alter the quality of their work could also reflect the specific nature of care work where the 'output' of the worker has a direct effect on the well-being of their elderly care-receiver. Instead, nine out of the twenty carers reported an intention or history of quitting jobs which they found unsatisfactory. Indeed, in most of these instances, the largest frustration was that they were not being allowed to perform as *well* as they wanted to and to meet their own professional high-standards. Common reasons for leaving jobs (or intending to) were where pay and promotion scales were deemed to be unmeritocratic (Clara, Maria), where colleagues were

[6] Again this may be a factor of the self-reporting nature of the study which relied on migrants' own descriptions of their job performance (Podsakoff et al, 2003).

allowed to get away with abusive behaviour (José), where there was insufficient investment in the carer's training (Gina), where wards were understaffed so that standards of care slipped (Clara, Gosia) or gender and/or race-based discrimination (Sharon, Ishayu). They were also most pronounced in the private sector. Staff in the NHS tended to feel sufficiently satisfied with their pay levels to avoid quitting and carers in the charity sector were positive about staff-resident ratios and the overall work environment.

There were certain narratives which rejected a sense of underemployment, or at least, stated explicitly that awareness that they were working well below a former grade or not utilizing any of their qualifications did not make them lose job satisfaction. These positive job outcomes will be discussed in more detail in a following section. A more common story, however, was one of a disconnect between the relatively high satisfaction that carers got from caring for the elderly and the low satisfaction that they got from the behaviour of unsympathetic managers. José, for example, had been victimised at work by a racist manager and was frustrated by the fact that 'it's all DNR [Do Not Resuscitate]' so he cannot use expert clinical skills developed in the Philippines and Australia. Yet he finds it difficult to contemplate leaving due to deep attachments to some of the residents and the satisfaction he gets from caring for them; he commented that 'just a smile will lift our hearts'.

5.3.3 Personal Outcomes

Feldman (1996) predicted negative outcomes for well-being as a result of underemployment. The finding from this study is that it is practically impossible to attribute work-related health impacts solely to a sense of underemployment, rather than generalised work stress or low job-satisfaction. Most of the instances of poor health (such as back injuries, headaches, exhaustion) were attributed by carers to the physically and mentally 'torturing' nature of care work (An). Several carers noted that understaffing was rife and this meant they were frequently so rushed that they were not allowed to sit for a whole shift or did not use hoists and other equipment as it would take too long to bring it to the patient. It was rarer that carers like Ishayu would defy the pressure from colleagues or bosses to work intensively and take the time to set up a hoist in order to protect their own health. Related specifically to a sense of relative deprivation or hierarchical underemployment, some carers described depression and feeling 'despondent'.

To conclude this section, the evidence reveals a mixed response to hypotheses h) and i). Stints of underemployment are likely to have a lasting downwards effect on career outcomes if they remain in the UK. Underemployment experiences tend to have negative effects on job satisfaction and workers' senses of wellbeing, albeit apparently not on job performance. They do, however, have a high influence on intention to quit among dissatisfied staff; empirical evidence which suggests one cause for the high rates of turnover witnessed in UK caring jobs. Job satisfaction and reduced reporting of underemployment's indicators occurred in the NHS and charity sectors, giving weight to hypothesis e).

5.4 Coping Strategies

5.4.1 Intersectional Considerations

As suggested in the coping literature, personality traits have a large influence on chosen coping strategies (Long et al, 1992). This relationship was not the main focus of this study, yet the research's attention to intersectionality does allow some broad observations on identity characteristics' relations to coping to be drawn. Firstly it was noted that coping strategies tend to alter over time; whether from youth to maturity or as familiarity with British norms and culture grew. Arlene, Sharon and Gosia remarked that when they first arrived they were shyer, less confident and more likely to 'go with the flow' rather than raise any grievances. For Arlene, this had a cultural element as in the Philippines she had been raised always to defer to the judgement of her elders and superiors. However, after four years working under a 'cold' manager who one day started shouting degrading and racist comments at her and another Ghanaian care assistant in front of other colleagues (which she deemed highly unprofessional), Arlene made clear that she objected to such treatment;

> *'I really won't forget that, because it's the first time I've spoken to someone older than me in my life [like that]. I mean I didn't use bad language, but now I would look at it just as standing up for myself, but then I had never done anything like that in my life.' Arlene, 51, Philippino, Care Assistant NHS, Surrey*

Whilst it would be overly simplistic to draw causal links between gender, race or age and coping strategies, these observations highlight that there is some influence of these

dimensions on an individual's negotiation of a stressful situation. On balance, most carers described using a combination of engagement and disengagement coping strategies in approximately equal measure as predicted in hypothesis l). The following sections will draw out the most common coping themes raised by carers.

5.4.2 Professional Performance

Much evidence was found to support Allan and Aggeggard's, (2003) observation that demonstrating excellent professional performance in the workplace buoys carers' sense of pride in their professional identity and sustains them through periods of feeling undervalued at work. Indeed, allusions to a desire to 'act professionally' in one capacity or another occurred 117 times in the transcripts. It is difficult to categorise this coping strategy as one of engagement or disengagement. Some carers felt driven to instruct other colleagues who they saw breaking protocols or forgetting training in how to do a procedure correctly, whereas others, such as Ishayu would only do this once or twice with another carer. If after that time they continued to give poor quality care, he refused to work with them any more in a strategy which maintained his own sense of high standards and professional pride. José and Gina reported similar behaviours. Again, no carer reported that they themselves underperform in order to balance out the sense of being insufficiently remunerated for their work or skills level; disproving the applicability of Feldman's original proposition to care work and hypothesis j). When they felt the need to disengage from work politics, discrimination or a particularly stressful shift, many of the carers would reassure themselves with examples where 'I've done my job and done it really well' (Maria).

5.4.3 Engagement

The theme of professionalism often overlapped with other engagement strategies. Where carers had developed the confidence to raise grievances with managers they tended to favour 'confronting' the issues according to professional protocol outlined in the care home's policies. Many carers underlined the value of clear protocols and adherence to official and contractual arrangements as it reassured them that they were operating in a professional environment and could protect themselves from exploitation. The most commonly cited engagement coping strategy where these arrangements were infringed was to confront concerns with managers in a professional manner. Where this approach failed,

some carers had tried to employ social support networks (such as unions) to address with the problem. Approximately half the interviewees were union members or had been in the past. Unfortunately, several carers remarked that, this was rarely a successful way of improving pay, promotion prospects or respect in the workplace as it often involved first fighting prejudice within the union system. Others also refrained from approaching unions 'out of respect for their work' or because it would make them look like a 'troublemaker' to managers (Gina, Paul and Clara).

Accepting responsibility represented a more introverted, yet nonetheless active and engaged method of coping with underemployment. Again, it seemed to bolster carers' sense of personal professionalism. Emerson, for example, underlined the need to be accountable for all caring actions. He summarised his coping strategy in the following way:

> *'A dialogue with your supervisor, and dedication and determination to improve. That's the only way. If you are determined and reflect and try as hard as possible, whether it's lack of training or experience, you try to find out the problem so it will not be repeated.' Emerson, 55, Sierra Leone, Deputy Manager in Private Sector, London*

5.4.4 Training Efforts

The value of training alongside daily care responsibilities was reiterated repeatedly throughout the interviews, giving weight to Burris' (1983) assertion that the 'opportunity to grow' can mitigate subjective forms of underemployment. Again this represents a coping strategy which is hard to categorise as engagement or disengagement. Most of the carers had undertaken NVQs alongside their work commitments which were frequently required by their employers. Others, such as Gina, independently sought and paid for Phlebotomy training. As Gina asserted:

> *'at the end of the day, we are not here just to spend a few hours at work, take the money and go home, we are here for evolution. Evolution means… I'm going to help you to be the best you can be.' Gina, 43, Romanian, Care Assistant, Private Sector, London*

Similarly for Sharon:

> *'If I get extra days [off] in the home, then I work in the hospital, because that's my dream. I don't want just to be stuck in a nursing home, I want my clinical skills to be updated… I want more growth. Learning is something you need to do in your day to day life, and so I*

think I need to learn more and if I could do better at what I'm doing right now'. Sharon, 38, Private Sector, Glasgow.

Training need not focus only on skills for job-related tasks. A positive example of this was demonstrated at one charity sector care home. This home was relatively unusual in the UK as it provided care only for Polish elderly and was staffed almost entirely by Poles. English proficiency was very low, but the manager encouraged all carers to attend English lessons amounting to six hours a week. This not only enabled them to complete NVQs and become better qualified; for young carers like Julita, who had come to do care work in the UK as a kind of gap-year in her college years, it represented an opportunity to broaden her transferable education. Gosia also observed holistically that she drew enjoyment from the life lessons she learnt from the elderly people she was caring for.

The opportunity to train; to acquire clinical knowledge of Alzheimer's, Parkinson's and other dementia-related diseases or to understand the correct moving and handling procedures were deemed by Alenka, Alicja and others to be a mark of professionalism for the care work. This made them feel valued both at work and in wider society. Unfortunately the efficacy of this coping strategy was undermined where care homes did not adhere to their own training procedures or where carers were not paid or given working time to completing it. Furthermore, as Feldman (1996) recognised in his original theory, this strategy is unlikely to ameliorate objective overqualification; a situation acknowledged by Dan, Alma, and Alicja who disliked the sense of being 'perpetual students' without promotion prospects.

5.4.5 Disengagement

Both Gina and Ishayu described switching from engagement- to disengagement-oriented strategies to as their attempts to improve their employment prospects or work environment went unappreciated by managers. Distancing and self-control strategies tended to include an element of self-preservation and were often associated by carers with the need to take a step back to avoid something unprofessional occuring in their interactions with other staff or residents. Examples of this tended to include taking short breaks, even if these were not authorised by management, as long as other team mates were not put under too much pressure in the meantime. This did not seem to extend to taking full days off sick, especially in the private sector where sick days were rarely paid. Instead, a few carers described

‘escaping’ by sleeping in most of their free time or doing other solitary activities which helped them ‘forget’ about work. Others disengaged by keeping quiet about elements of the work environment which they were unhappy with and instead channelling their energies into retraining. Dan and Paul, felt that their career fulfilment was hampered by their gender (as discussed above), so both disengaged from certain residents (especially females who also objected to their race) and instead developed niche specialisms for dealing with men, in particular men with challenging or aggressive behaviour.

A sense of humour emerged as a positive –reappraisal coping mechanism in over half the interviews. Safiah observed that you ‘have to have it’ in order to survive and succeed in care work. It was used as a way to subvert the increased surveillance that foreign carers felt they were under; José joked about looking for hidden cameras which have been used in the past to observe carers’ behaviour[7] whenever he goes to give personal care to a patient. He also said that humour helps migrant carers to make light of the most unpleasant aspects of care work;

> *‘Sometimes we just joke about it. Every time we wipe bums, we are sending this money to our relatives – every time, £1, £1, £1 (laughs)’. José, 40, Philippino, Care Assistant, Private Sector, Glasgow*

Dan and Alicja both noted that humour can even be used like a professional skill for calming agitated residents and dispelling tension when colleagues have a challenging episode.

As José’s quote above suggests, another coping strategy which carers described was the reassurance that their work in the UK was securing a better life for their families or their future selves (also Irina and Clara). Only a minority were expected to send remittances and few had plans to ultimately return to their home countries. However, those who did were sustained by the knowledge that their future there would be more luxurious and secure. Whilst this is arguably a universal motivator for any worker through times of stress, migrant workers from relatively poorer countries are able to exploit the higher value of pound

[7] This theme recurred often in the transcripts. It follows the showing of a BBC Panorama documentary ‘Undercover: Elderly Care’ (http://www.bbc.co.uk/programmes/b01gybn7 Accessed 28.06.12) which revealed abuse taking place in a care home and subsequently dominated news headlines. Carers such as Joseph and Dan objected to the emphasis this documentary placed on the race of the perpetrators of this abuse; Philippinos and Africans. Four of the carers felt that the surveillance they experience due to their race and frequency of false accusations of abuse had intensified in the wake of this documentary.

sterling and achieve a level of material comfort higher than if they had not worked abroad or planned to remain in the UK. Paul for example was building a retirement home for himself in Nigeria and Clara was able to invest in a successful solar panel business in Zimbabwe which would eventually provide her with a pension; alongside being able to fund the university places of her children. Others found other outlets within the UK more helpful, not least as most felt that the UK had become their 'second home' (Maria). Many were active in non-work circles. Some found this solace by joining churches, others in ethnicity-based groups which shared cultural pursuits and others took part in migrant rights activism or union activities. Arlene, for example found satisfaction through teaching traditional Philippino dancing, and Gina felt that maintaining 'solidarity' with her co-workers through union membership was important for her sense of self as a hard worker.

5.4.6 Teamwork and management

A final theme which emerged strongly was the influence of colleagues and managers on reinforcing or reducing senses of underemployment. From a positive perspective, some carers noted that the sense of teamwork with their colleagues – of local and migrant background alike – made them feel valued for their professional skills. Emerson, for example, said the best experiences were when nurses, care assistants and doctors worked together in a multi-disciplinary team. He and Afua felt this approach was vital in care work where one must care holistically for the elderly person; taking in not only medical changes but also mood-swings and alterations of disposition. Safiah and Gosia too underlined that the lower hierarchical position of care assistant failed to reflect the unique expertise that those performing day-to-day personal care developed with their key charges. Recognition of this from colleagues, managers and other health professionals is therefore important in dispelling senses of relative deprivation underemployment. As Safiah and others noted, a sense of value is vital for creating a good quality care environment:

> *'The other ability to influence [your work situation] is your relationship with your line manager. Whether they are prepared to listen. And that is pivotal to how you create a workforce that actually feels they have an investment. A member of staff feels, or every member of staff feels they can influence, that means they can invest'. Safiah, 58, Malaysian, Project Lead, NHS, Glasgow*

Susan felt that her positive relationship with her boss, especially in arranging flexible working hours following maternity leave was what prevented her from quitting her present care job. Gina and Gosia both attributed their present confidence in their abilities to having had initial placements in care homes with sympathetic and encouraging managers who took pride in high standards. Furthermore, as An and Susan noted, acceptance as an equal by British co-workers helped them feel integrated into wider society; an important consideration for migrant workers hoping to cement their future lives in the UK.

This dynamic is undermined, as one might expect, when other team members do not do an equal share of the work (noted by Asa, Ishayu, Alicja and Afua) or when team-mates and managers perpetuate discrimination. Senses of relative deprivation were likely to arise in these cases. Joseph, for example, observed that those with five-year work permits (whereby a migrant is only allowed to remain in the UK whilst they are in work) were exploited by certain managers and colleagues with permanent citizenship. In his case, working in a care home run by a 'totally unprofessional' manager, those without work permits were given the worst hours and tasks and had no way to raise grievances. He was told by another migrant carer with resident status to 'just do what you were told to do. You can complain after five years'. Managers who did not recognise a worker's qualifications or expertise, as Maria described, had the potential to deeply reinforce feelings of relative deprivation and depression. The qualities that were most valued in a manger were the chance to speak openly and as equals on concerns about managing care on the ward, presenting a united front against racist behaviour amongst residents or their families, having transparent, meritocratic promotion protocols and praising or encouraging good quality care provision.

To conclude these coping strategies observations it is evident that a combination of coping methods are used by carers, both individually and *en masse* in order to cope with both underemployment and generalised work stress. Long et al's (1992) coping typology was a useful framework for emphasising agency; whether a worker engages proactively with stressors in an attempt to remove them, and disengagement; where a worker deems it more appropriate to withdraw from the situation. In order to fit these concepts more appropriately to reality and the migrant condition, however, it was necessary to see only a blurry line between engagement and disengagement, remembering that the choices of

migrants may be constrained by discriminative practices and prejudice which less often affect non-migrants. The strongest themes emerging in this section were the importance of fostering strong professional identity, a sense of humour and respectful relations between managers and co-workers.

5.5 Underemployment rejected

The final part of these results will present stories from carers who rejected the label of underemployment. Regardless of whether they might be objectively over-qualified or hierarchically demoted, several carers presented narratives which defied a causal link between these circumstances and a resultant sense of underemployment.

Many of the carers rejected a linear idea of career trajectories and preferred instead to consider their time as a carer as a diversification of their skills base. Several were optimistic about their chances of combining their care capabilities with other existing areas of expertise. Irina and Alicja, for example, were attracted by the idea of re-utilising their Polish teaching qualifications and becoming accredited trainers of new carers in the future. Asa had originally arrived with the intention of studying business, yet switched to Health and Social Care studies when she found that her part-time work as a carer was her real vocation. She hoped in future to combine both these interests and eventually establish her own private care home. Paul too had arrived as a Law student but had found it impossible to earn enough money to support himself and pay the course fees. He has since become a union official alongside work as a care assistant and, when asked how he viewed his transition from lawyer to carer, he made the following observation:

> *'I would not lie, it's difficult, but now that I have been in the trade union, it seems to bring the two together for me. Now I am doing a Diploma in Employment law, that is part of it, so you can see now I am working around it to make sure I never lose the foot[hold].' Paul, 49, Nigerian, Care Assistant and Union Representative, NHS, London*

It could be argued that several of the positive outcomes described are inseparable from the interviewees' experiences of being a migrant. Afua, for example, stated that 'Moving is an achievement, a very big achievement, you get confidence [from it]', and this outweighed any daily work frustrations. Having worked as a secretary in Ghana she felt that her social

status had been lowered somewhat by beginning work in care – she observed that some people think you would only do this work if you are 'hungry' or desperate. But she had in fact used her move to the UK to make a break with her previous career and enter a field where she could fulfil her 'passion to be a carer'. Paul, as the son of a village chief, would never have done caring work in Nigeria, yet he described a great sense of job satisfaction from caring for the elderly. Furthermore, he liked that doing this work in the UK had made him 'eye opened' and 'advanced in my education and my thinking'. When he returns to Nigeria he enjoys passing on his new-found values of equality between people of different social status, race or gender which he has discovered in the UK. Dan, who expressed much greater job satisfaction as a carer than in his former career as a shipping firm manager, particularly enjoyed the sense that British society has less hierarchy than his native India. He felt liberated by escaping the class, caste and reservation restrictions in India which had shaped his previous employment decisions. The achievement of securing a permanent job in the UK was sufficiently impressive for his family back home that he did not feel that they disapproved of his switch from a 'white collar job' to a 'low job' involving personal care.

From a purely practical perspective, Irina, and Alicja commented that they would have been unable to earn sufficient wages as teachers in Poland to live the independent adult lifestyles they aspired to. José and Paul similarly noted that without the relatively higher salaries in UK care jobs, they would still be living with their parents and would have been unable to start and support their own families. Yet, it was apparent in many of the interviews that money alone is not what keeps carers in their jobs. Some relished the personal and professional challenge of dealing with difficult dementia cases (e.g. Gosia, Dan, Gina and Asa). Having accepted promotions and pay rises, care managers including Irina, Emerson, Clara and Gosia lamented their increased paperwork and missed the one-to-one contact with the elderly that they had had. Having brought a deep respect for the elderly from their home cultures many of the migrant carers felt care work enabled one to 'bring out your best' (Asa). They described the opportunity to care for the elderly as a 'privilege' (Alicja) and a 'blessing' (Ishayu). These sentiments of empowerment should not be forgotten in the wider discussion of migrant carers and underemployment.

6.0 Discussion & Conclusion

6.1 Empirical Answers

In answer to this study's research question – **How do migrant workers become vulnerable to, experience and cope with feelings of underemployment in the UK care sector?** - the following will outline the findings related to each of its sub-questions.

1. **What are the antecedents of underemployment for the studied group?**

Migrant workers display some of the same micro-level antecedents as the generalised population; particularly job search strategies, employee experience and traits, and personal work preferences (Feldman, 1996). These tend to take on a different form in the cases of migrants, however. Job searches are more likely to be intensified or rushed due to concerns about meeting visa requirements. Alternatively, they may be directed by other actors such as agents who may not view the migrant's experience in its entirety. A significant employee trait which impacts the level and type of job which a migrant can secure is English proficiency and familiarity; this again sets them apart from local people. In certain other cases where neither of these antecedents played a role, it was instead the personal preference to work in jobs with less responsibility or in more convenient locations which made migrants objectively underemployed, but satisfied with their personal lives.

Other expected antecedents such as job type and career history do not seem to exert the same effect for migrants as Feldman predicted. Those with a higher position in care institutions were less likely to feel underemployed, even where they were still objectively overqualified for their role. This reflected the sense that their initial hard work as a care assistant was being rewarded by progression, promotion, professional recognition and increased salary. Histories of being laid-off or underemployment were rare amongst the sample with only three interviewees describing episodes like this. It seems instead that lower English proficiency, lack of recognition of foreign qualifications, negotiating confusing immigration procedures and the pressure to support oneself without assistance from family or the state compel migrants into underemployment; whereby any job is better than no job.

Finally, however, migrants described numerous examples of racial and sometimes gender-based discrimination within the workplace which they felt significantly limited their promotion chances and ability to be paid according to their skill level.

2. Which elements of underemployment do migrant care workers describe?

Migrant carers described many forms of underemployment, with a different degree of objectivity or subjectivity depending on a range of mitigating factors. Dimensions of underemployment which were mentioned included pay and hierarchy underemployment, overeducation, skill underutilization and relative deprivation. They did not, however, describe underemployment on the basis of job-person incongruence, stating instead that, in spite of the sense they are undervalued, most maintained a vocation for care work. Nor did carers describe being unable to work as many hours as they wish; unsurprising in an industry which experiences labour shortages and requires staff to work very long shifts.

Two significant external mitigating factors of whether one felt objectively or subjectively underemployed (i.e. not related to the personal history or actions of the worker themselves) were identified by the interviewees. These included discrimination (whether in the workplace or through the immigration system) and sectoral differences. The former was regularly associated with feelings of objective hierarchical underemployment, job-field underemployment and subjective relative deprivation resulting from pressurised job searches or prejudice from colleagues and supervisors. Regarding sectoral differences, migrant carers in the charity sector noted that their pay was relatively low (indicating objective pay underemployment), but their opportunities to be trained well and work in a pleasant environment outweighed this (indicating job satisfaction and a reduction in subjective skill-underutilization and relative deprivation). By contrast, those in the private sector were more likely to report that their pay, training, and work environment suffered from underinvestment, reinforcing feelings of objective and subjective underemployment. Senses of underemployment tended to have less relation to internal antecedents (e.g career history) unless they had prior experience in nursing or management fields.

In several cases, nonetheless, the null-hypothesis was identified. Although individuals may be objectively overqualified, overworked and underpaid, the passion they felt for their

profession was an overriding sensation, leading them to reject an accompanying sense of subjective underemployment. Ultimately the finding regarding subjective and objective underemployment was that there is no guaranteed concurrence of the two; objective antecedents of underemployment might exist, but subjective assessments of underemployment mitigate whether carers report a sense of overall underemployment.

3. What are the consequences of underemployment for these workers?

Certain of Feldman (1996) and McKee-Ryan and Harvey's (2011) predictions for underemployment consequences were borne out in the interview data. In the majority of cases migrants described the sense of their career trajectory dampening as a result of working in care. Observations on overeducation, relative deprivation and pay/hierarchy underemployment were often accompanied by negative feelings, lower job satisfaction and an intention to quit. They were rarely followed, however, with descriptions of reduced job-performance, disproving Feldman's hypothesis on this point. It seems that a duty of care is more likely to outweigh personal frustrations in care environments. That 'underemployment hurts' (Maynard and Feldman, 2011) on an emotional level, however, was hardly disputed by those interviewees who felt they were working below their deserved grade.

4. How does this group cope with the sense of being underemployed?

This study has collated a wide range of anecdotes on how carers manage the sense of being underemployed. In accordance with existing coping strategy theory, it seems that the choice of coping strategy is most likely to relate to the personality tendencies of the given individual. Beyond this, however, certain cross-cutting themes emerged strongly which suggest that migrant carers face specific personal and work-related circumstances which make some coping strategies more prevalent (and perhaps more effective) than others. Disengagement strategies were more pronounced when migrants were new to the UK and unfamiliar with the language or norms. Distancing, self-control and finding ways to 'escape' the pressures of care work were noted in cases where migrants experienced employment discrimination alongside the existing challenges of their daily jobs. Positive-reappraisal was nonetheless regularly noted by carers. Jokes, irony and humour abounded in the interviews. Strongly emerging engagement strategies encompassed the desire to confront problems with the assistance of management and to uphold high professional standards of care-

giving. The imperative to work professionally not only strengthened the individual's positive sense of self in the face of discrimination and relative deprivation, but enabled migrants to meet other priorities in their lives. These included supporting families in the UK and abroad, earning citizenship status and feeling an overall sense of achievement from the migration.

Finally, migrant carers presented several concrete strategies which they felt would allow them to cope better with feelings of underemployment. These included improving relationships with managers and team members, encouraging specialised training and implementing transparent, meritocratic promotion structures. At the most basic level, simply hearing 'thank you' more often would be an improvement on the current situation.

6.2 Evaluation of the Quality of the Research

When taken as an exploratory study, this project successfully captured a diverse array of migrant stories; in terms of migrant origins, work experiences, immigration status and location in the UK. It represents for the first time a detailed consideration of underemployment theory in application to migrants and carers. Nonetheless, the research can hardly be called representative in a statistical way due to the small sample size and self-selection bias. It would be valuable to use this study as a pilot for a larger piece of research which could involve a larger sample, taking in more carers from different sectors (in particular the charity sector which this study found challenging to access) and origins. It would also be revealing to access migrants who are more recent arrivals in the UK or 'irregular' in terms of legal immigration status. These migrants are likely to have even less familiarity or autonomy within the UK system and may be more vulnerable to underemployment than those captured by this study's methodological approach. Furthermore, in order to gain a more informed insight on whether caring jobs function as 'stepping stones' or 'entrapments', it would be worthwhile to survey a larger sample of migrant workers or to re-interview this sample at a later date. This could highlight examples where migrants have been able to move out of the sector if they so wished, and demonstrate more comprehensively what effect care jobs have on career trajectories.

On a theoretical level, to address any one of underemployment's antecedents, experience, consequences or coping strategies could comprise a single thesis in itself. This study's

breadth is arguably its greatest weakness and future investigation should more closely focus on its components. This process could also address a second concern which is that 'catch-all' theories for explaining underemployment or coping are too abstract to draw out the specific and nuanced experiences of specific social groups. Their sub-components need more refinement and operationalization if they are to be used meaningfully. Different theoretical frames which could be used in future include an analysis of worker-supervisor relationships (Newsome and Pillari, 1992) or stress caused by role ambiguity (Chang and Hancock, 2003).

6.3 Contributions to Existing Theory and Future Investigations

In spite of its limitations, this research has made notable contributions to existing theory. Most pertinently, it has highlighted a tendency within Feldman's (1996) underemployment theory to focus on *internal* antecedents (i.e. those in which the individual has had some agency, such as their career history, job search or personal work preferences). What this study has found is that it is vital to look at *external* antecedents of an individual's underemployment. These may vary according to the demographic group in question, but for migrant workers in particular, the role of racial discrimination in the workplace and wider society should not be ignored when formulating a balanced picture of underemployment. This challenges existing underemployment schemas. Arguably, listing 'demographic characteristics' as an antecedent does not go far enough in demonstrating the role of social structure in creating migrant underemployment. A second external antecedent which was identified was the influence of work environment – which in the care industry differs on a sectoral and even home-by-home basis – on carers' subjective underemployment. Thus this study underlines the need for underemployment theory to be more outward looking if it is to reflect the reality for migrant carers; who face antecedents beyond their own control.

The study has also met its objectives of adding an element of pragmatism to the study of underemployment and seeking to acknowledge migrant carers' empowerment. It has empirically linked underemployment theory to coping theory and underlined the ability of certain individuals to resist underemployment traps; whether through subjective reappraisal or through actively altering personal or work circumstances. This stands in opposition to existing literature which presents negative forecasts of underemployment as an upwards linear trend in post-industrial economies (Ng and Feldman, 2009; Vaisey, 2006).

Further to this, the study has highlighted a number of interesting avenues which future research on underemployment and migrant carers could take. These could include;

- A comparison of migrant carers with British-born, (white) carers. This would extend investigation of discrimination as a social structural antecedent of underemployment.
- A closer attention to the intersectional dimension of class; what effect does a migrant's perceived status pre- and post-migration have on feelings of underemployment?
- An investigation of the role of training in ameliorating underemployment; to what extent does training help workers cope or feel stimulated vs. reinforcing objective overeducation?
- An analysis of the impact of individual underemployment coping strategies on career trajectories. E.g., what effect does quitting have on ultimate career outcomes?

6.4 Relevance and Recommendations for Policy and Interventions

In some ways, this study has functioned like an employee performance review, in which the policies and practices of the care sector have been interrogated. As a result, it has revealed a number of observations on what does and does not function effectively from the point of view of maximising worker utility and job satisfaction. These have great relevance to care home managers, policy-makers, unions and migrant organisations. They include the need to;

- **Promote Caring as a Profession**: Frustrations regarding feelings of low status and poor hierarchical prospects amongst carers stood in opposition to their own perception of care work as a skill and profession. A sea-change in the way society values and views carers could ameliorate these senses of relative deprivation. Whilst this is a fairly nebulous proposition, it could be achieved somewhat by putting efforts into the following;
- **Invest in training provision for all care workers:** The provision of regular training with new and stimulating content reinforces the sense that carers are skilled and well-educated workers who can take pride in their academic and career achievements. This should be delivered by qualified teachers and result in recognised credentialing which can be transferred within the care sector. Carers felt that a trend towards on-line, solitary training which must be taken in the employee's own time cheapened the experience of training, making them feel undervalued. NVQ training and other specialised care qualifications should concurrently be made accessible and affordable to all those carers with the ambition to upskill. This would also involve provision and support for migrant students seeking to

study Health and Social Care in the UK, but who have fallen victim to rogue colleges which have charged course fees without providing education in return.

- **Provide work-related English Lessons for migrants:** The present recession has meant that funds for migrant English lessons have been retrenched. Bringing these back with a work-orientation would, however, have a value-added function for the migrant workforce and economy alike as it unlocks existing skills, making expertise translatable for use in the UK.
- **Train Managers to stamp out discrimination and promote morale:** Managers who do not tolerate prejudice in the workplace have a significant uplifting effect on worker morale and sense of job satisfaction. In a sector where pay rises and promotion opportunities are rare, the creation of a discrimination-free work environment which encourages professionalism and recognises good work can nonetheless imbue workers with a sense of value and help them cope. This and other research suggests that this could also reduce turnover rates.
- **Reduce carer to care-recipient ratios:** Whilst it did not comprise the central focus of this research, incidental evidence revealed that workers feel their professional skills cannot have full application in environments where they must constantly rush from one elderly patient to the next. Allowing carers to take the time to develop quality rather than quantity of care would reduce the sense that they are there just to do physical labour. This might also reduce the need for unpragmatic coping strategies which demand an 'escape' from work.
- **Improve Union responsiveness to migrant carer grievances:** Where carers are unable to engage and confront problems of discrimination at work, they require another outlet or source of support. Another incidental observation from the research was that unions should improve their representation of migrant members. Unions could proactively lobby for improved training opportunities and for the recognition of foreign qualifications where they meet the necessary quality assurance standards. They could also tap into international union networks in order to promote information sharing for future migrants to the UK in a bid to reduce the barriers of unfamiliarity that face new arrivals.

These suggestions for the future represent the culmination of this research. In a study based on the stories of migrant carers, it seems fitting that the last word should remain with them;

> *'There are a lot of skills are out there - especially in the foreign-trained coming from the Third World, because there you are the doctor, the nurse, everything'.*
> *Clara, 58, Zimbabwean, Care Manager, Private Sector, London.*

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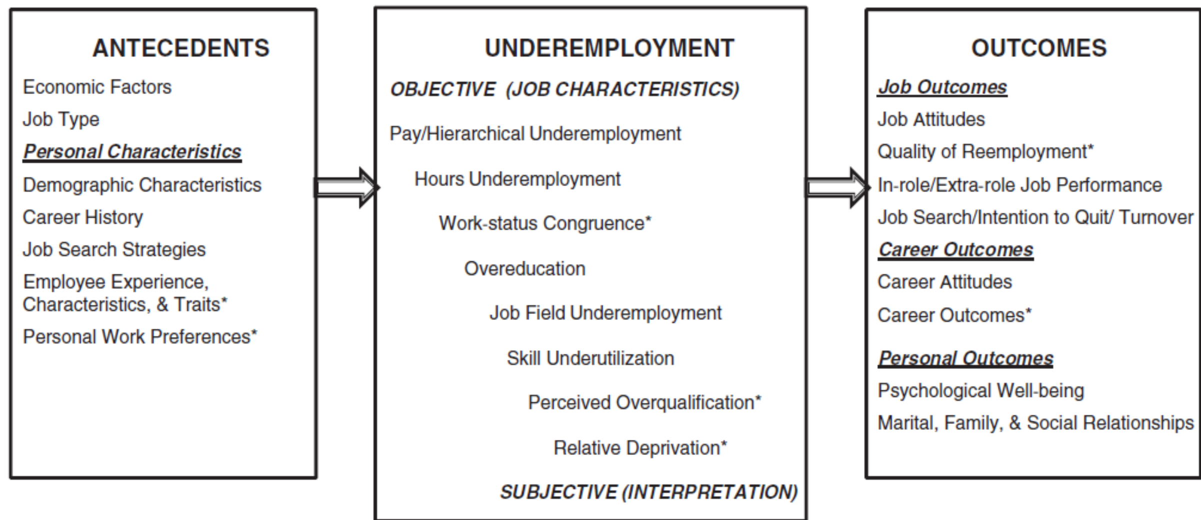
8.0 Appendices

Appendix 1 - Theoretical Approaches to Underemployment

Source: McKee-Ryan and Harvey, (2011)
Note: The central box displays underemployment experiences on a continuum from the most objective to most subjective as deemed by the authors.



*Indicates dimensions added since Feldman's (1996) review.

Appendix 2 - Propositions and Support for Feldman's (1996) Underemployment Review

Source: McKee-Ryan and Harvey (2011)

'**←**' and **Bold Propositions** highlight the propositions to which my study will make a contribution drawing from migrant care worker cases.

Propositions From Feldman's (1996) Underemployment Review

Propositions (with original numbering)	Level of Support
Antecedents of underemployment (Und)	
Economic factors	
P1: Levels of Und will rise as (a) recessionary pressures increase and (b) concerns about governmental regulation of labor costs increase.	a. Some support b. No explicit tests
P2: Levels of Und will be higher among workers (a) in declining firms than in steady-state or growing firms, (b) in declining industries than in steady-state or growing industries, (c) in declining subunits than in steady-state or growing subunits.	Some support that Und varies by industry
Job type	
P3: Levels of Und are likely to be higher (a) among managers than among nonmanagers; (b) among staff workers than among line workers; (c) among marketing and R&D employees than among finance, accounting, and law professionals.	Some support that Und varies by profession ←
Demographic characteristics	
P9: Und will be higher (a) among women than among men and (b) among racial minorities than among whites.	Mixed Results ←
P10: Und will be positively correlated with age.	Mixed results (←)
P11: Und will be negatively correlated with education.	Mixed results ←
Career history	
P4: Individuals who have been laid off are more likely to experience Und than individuals who have been continuously employed.	Some indirect support
P5: The longer an individual is unemployed, the more likely he or she is to become Und.	Some support
P6: Individuals who are career plateaued are more likely than their coworkers to become Und.	No explicit tests ←
Job search strategies	
P7: Und will be inversely correlated with (a) an early start to job hunting and (b) an intensive job search effort.	Some indirect support ←
P8: The use of geographical relocation and retraining to obtain new jobs will be inversely correlated with Und.	No explicit tests ←
Underemployment (Und) outcomes	
Job outcomes	
P12: Und will be negatively correlated with job attitudes (e.g., job satisfaction, work commitment, job involvement, work motivation).	Support ←
P17: Und will be negatively correlated with job performance.	Mixed results ←
P18: Und will be negatively related to organizational citizenship behaviors.	Some support
P16: Und will be positively correlated with (a) turnover and (b) absenteeism.	a. Mixed Results ← b. No explicit tests
Career outcomes	
P15: Und will be positively related to careerist attitudes and behaviors.	Support
P14: Und will be inversely related to attitudes toward careers.	Some indirect support ←
Personal outcomes	
P13: Und will be negatively associated with psychological well-being (e.g., overall life satisfaction, optimism, self-esteem).	Support ←
P19: Und will be inversely related to quality of interpersonal relationships with (a) spouses, (b) children, and (c) friends.	Some indirect support

Appendix 3 - Coping Strategies grouped into 'Engagement' and 'Disengagement' categories

Sources: Coping Strategies: Folkman et al (1986) / Categories: Long et al (1992)

Engagement Coping

Confrontive coping describes aggressive efforts to alter the situation (e.g., "stood my ground and fought for what I wanted," "tried to get the person responsible to change his or her mind"). It also suggests a degree of hostility (e.g., "I expressed anger to the person(s) who caused the problem") and risk-taking (e.g., "took a big chance or did something very risky," "I did something which I didn't think would work, but at least I was doing something").

Seeking social support describes efforts to seek informational support (e.g., "talked to someone to find out more about the situation"), tangible support (e.g., "talked to someone who could do something concrete about the problem"), and emotional support (e.g., "accepted sympathy and understanding from someone").

A*ccepting responsibility* acknowledges one's own role in the problem (e.g., "criticized or lectured myself," "realized I brought the problem on myself") with a concomitant theme of trying to put things right (e.g., "I apologized or did something to make up," "I made a promise to myself that things would be different next time").

Planful problem-solving describes deliberate problem-focused efforts to alter the situation (e.g., "I knew what had to be done, so I doubled my efforts to make things work") coupled with an analytic approach to solving the problem (e.g., "I made a plan of action and followed it," "came up with a couple of different solutions to the problem").

Disengagement Coping

Distancing describes efforts to detach oneself (e.g., "didn't let it get to me—refused to think about it too much," "tried to forget the whole thing"). Another theme concerns creating a positive outlook (e.g., "made light of the situation; refused to get too serious about it," "looked for the silver lining—tried to look on the bright side of things").

Self-control describes efforts to regulate one's own feelings (e.g., "I tried to keep my feelings to myself," "kept others from knowing how bad things were") and actions (e.g., "tried not to burn my bridges, but leave things open somewhat," "I tried not to act too hastily or follow my first hunch").

Escape-Avoidance describes wishful thinking (e.g., "wished that the situation would go away or somehow be over with") and behavioural efforts to escape or avoid (e.g., "tried to make myself feel better by eating drinking, smoking, using drugs or medication, etc."; "avoided being with people in general"; "slept more than usual"). These items, which suggest escape and avoidance, contrast with the items on the distancing scale, which suggest detachment.

Positive reappraisal describes efforts to create positive meaning by focusing on personal growth (e.g., "changed or grew as a person in a good way," "I came out of the experience better than I went in") It also has a religious tone (e.g., "found new faith," "I prayed").

Appendix 4 - Summary table of Interviewees

Region of origin	Alias	Country of Origin	Gender F=14, M=6	Location in UK	Age	Length of time in UK (years)	Job/Workplace description NHS = 5, Private =11 Charity=4	*n*
South-East Asia (9)	Arlene	Philippines	F	Surrey	51	30	Care Assistant, NHS	1
	Joseph	Philippines	M	Central London	39	6	Care Assistant, Private	2
	Safiah	Malaysia	F	Glasgow	58	40	Project Lead, Nurse, NHS	3
	Sharon	Philippines	F	Glasgow	38	10	Nurse +Manager, Private	4
	Maria	Philippines	F	Glasgow	40	12	Care Assistant/Nurse, NHS	5
	Jose	Philippines	M	Glasgow	40	10	Care Assistant/Nurse, Private	6
	An	China	F	Glasgow	35	9	Nurse in Rehab Unit, NHS	7
	Dan	India	M	Reading	37	6	Senior Carer, Private	8
	Ishayu	Nepal	M	Hampshire	31	3	Care Assistant, Private	9
Africa (5)	Paul	Nigeria	M	Greater London	49	14	Care Assistant, NHS	10
	Afua	Ghana	F	Greater London	41	11	Care Assistant, Private	11
	Clara	Zimbabwe	F	Greater London	58	7 (1970's), 11	Deputy Manager, Private	12
	Asa	Nigeria	F	Greater London	25	2	Care Assistant, Private	13
	Emerson	Sierra Leone	M	Central London	55	20	Deputy Manager, Private	14
Eastern Europe (6)	Alicja	Poland	F	Greater London	38	4	Support Worker, Private	15
	Gina	Romania	F	Greater London	43	4	Carer, Private	16
	Alenka*	Poland	F	Kent	40	10	Carer, Charity, before Private	17
	Gosia	Poland	F	Kent	23	4	Deputy Manager, Charity	18
	Julita*	Poland	F	Kent	22	1	Carer, Charity	19
	Irina	Poland	F	Kent	41	4	Manager, Charity	20

*These interviewees could not speak English. They gave informed consent after it was translated for them by their Managers. The Deputy manager acted as interpreter during these interviews. The high potential for gatekeeper influence means that certain of their answers, particularly regarding relations with colleagues or management must be acknowledged and was remembered during analysis stages. Their interviews nonetheless gave a rare insight into ethnicity-based charity care in the UK.

Appendix 5 - Informed consent scheme

To be read to all candidates before the interview and recording commences:

I am now going to ask if you consent to have an interview with me both before and after I begin recording. I will be asking you about your experiences of migration and work in care and I am doing this to help me write a final project for my university.

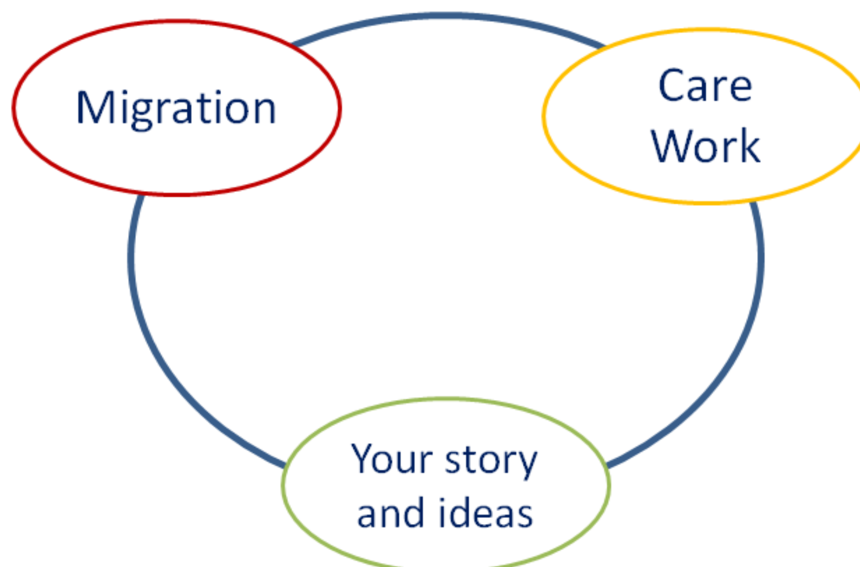
- The interview should last between about an hour and an hour and a half.
- You have the opportunity to ask for the interview to be stopped at any time and to refuse to answer any questions which you are not comfortable answering. You do not have to reveal anything about your personal circumstances which you do not want to tell me.
- You have the opportunity to contact me after the interview to ask that anything you have disclosed not be used in the final report.
- Your name and the place you work will be kept anonymous.
- I will ensure that this recording is kept confidential within the research project– it will simply help myself and my research group remember what we talked about before I write my final report.
- If you wish, I will send you a copy of the final report.

Is that ok with you? If you are happy to go on, I will record the interview using a Digital Voice Recorder.

If consent is given, switch on the recorder and reconfirm that they are happy to participate in the interview and for it to be recorded so there is an oral record.

If consent is not given, continue with the interview, making detailed notes during the interview as far as possible without introducing breaks to the conversational flow, and immediately after the interview. Consent was only withheld on one occasion in interview #11. On reflection, taking notes during and immediately after this interview did not prevent a valuable amount of data from being collected. Taking notes during the interview did, however, interrupt the flow of the conversation somewhat, which might have made this interviewee less forthcoming overall.

Appendix 6 - Interview Structure Diagram



Appendix 7 - Semi-structured interview scheme

Developed from the Care Migration scheme in conjunction with Bernhard Weicht and tailored to the research questions of this thesis.

Can you tell me something about how you came to live in this country?
- Highlight social networks, decisions made in country of origin
- Highlight decisions made since arriving – ie why live in this particular area?

How did you come to work in elderly care?
- What job search strategies were used?
- Was it their preferred area to work in?

Can you tell me something about the work you are doing?

How would you describe the work you're doing?
- Description of care work in general and own job in particular
- How do you describe your job and the work you're doing to friends or family?
- What is the official description of the job?

Can you tell me something about your day to day experiences doing this work?
- Positive/negative experiences doing the work?
    - Especially hours, pay adequacy *(be sensitive here)*
    - How are their skills used / developed?
- How do you cope with any negative aspects of your job that you've described?
    - Job performance: working harder / less hard?
    - Changing job attitude?
    - Planning to quit/change position?
    - Talking with managers / recipients in order to change the situation (see also later question re: representation)
    - Talking with other people working in the same situation / wider community
    - Focussing on friends/family / future at home

If you compare your job and your work now with your work in your country of birth, what are the differences?
- Career & Education History
    - What studies did they undertake before moving to the UK (and since)
    - What job(s) did they do before
    - Do they feel that the current job is a step 'forwards' or 'back'?
    - Do they get to utilise their experience & training
    - Will the current work help them in future career moves?
- Socio-economic perceptions
    - Status/class/education in country of birth?
    - Perceived status/class in the UK?
    - Perception of own professional status & hierarchy
    - How do others see these differences?

What do you think about how care for elderly people is arranged in the UK? And in comparison to your country of birth?

- Perception of care regime in the UK?
  - Perception of differences between elderly care in UK and country of birth?
  - Opinions about UK care arrangements
  - Ideas/opinions about family

Can you tell me something about your experiences with colleagues/clients/families of clients/management/other professionals?

- Relational context - do they have adequate recognition?
  - Experiences with colleagues
  - Experiences with clients
  - Experiences with clients' families
  - Experiences with management
  - Experiences with other professionals (e.g. doctors)
  - Experiences with general public/authorities

In how far do you feel you can influence the circumstances and arrangements of your work?

- Political representation/participation:
  - Legal status *(be sensitive here)*
  - Labour market status
  - Existence of unions/workers' organisations
  - Possibility of participation in unions
  - Possibility of participation of industrial action
  - Possibilities of participation in defining and shaping work circumstances

Can you tell me something about your plans/ideas about your future? (Work, family, country of living etc.)

- Ideas about future career
  - Remain in care work?
  - Do new qualifications / training?
  - Move into different work?
- Ideas about future with family
  - What future arrangements do they expect?
  - With children / parents?
- Ideas about future location
  - Do they hope to stay in UK / move back home?