A critical examination of workplace well-being and employment experiences

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Abstract

Experiences of well-being vary depending on the context. A key life pursuit that consumes a third of adult life, work is fundamental to both individual and societal well-being. This thesis examines the intersections between well-being and workplace experiences. This examination is conducted within the context of the New Zealand aged residential care sector (ARC) which for some time has been witnessing both an increase in the numbers of an ageing population needing care and labour shortages. This has necessitated the employment of migrants as care workers. Despite the increased participation of migrants in the New Zealand ARC sector, there is still a dearth of studies that examine the interface between their well-being and work experiences. A critical feminist ontological and epistemological paradigm enables the examination of the interplay among aspects of the work environment, migrant identities, and the neoliberal business policy environment in which aged care facilities operate and how they impact on migrant care workers' well-being. The use of semi-structured interviews aligns with the ontological and epistemological premises of this study regarding the nature of reality as multiple and therefore captured by creating an environment where researcher and the researched interact in co-creating knowledge.

The findings of this thesis demonstrate that workplace well-being is influenced by three interconnected factors. First, are the participants' largely negative pre-migration experiences combined with their migrant identities and temporary legal status in New Zealand. The temporary visa status is particularly a significant negative influence on migrants' well-being. Secondly, well-being is influenced by factors of the work environment, such as the nature of the job and workplace relationships. The nature of aged care work as 'dirty body work' is especially critical to well-being as it is tied to physical, social and emotional taint. The other important work environment factors include heavy workloads, work intensification or care speed-ups, irregular work hours and shifts, and the perceptions of discrimination around issues such as rostering and allocation of jobs. In studying well-being, extant models point at factors internal to the organisation as crucial to levels of workplace well-being. This approach suggests that improving workplace well-being is largely the preserve of actors within the organisation such as owners of residential aged care facilities, individual managers/supervisors and individual employees. This thesis argues that it is important to be mindful that the interactions that take place among these actors happen within a care regime that is largely influenced by a neoliberal business policy environment whose key tenets include commodification of labour and cost-cutting work practices. Therefore, the final

factor impacting well-being is the neoliberal business policy environment that shapes care regimes and work conditions that have an impact on well-being. This thesis therefore extends the extant approaches to the study of workplace well-being by incorporating the examination of migration, migrant identities, work conditions and the neoliberal business policy environment in which ARC is provided. This enables a holistic approach to the crafting of recommendations that can improve the well-being and workplace experiences interface.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

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Chapter 1: Introduction

Globally, there is compelling evidence that well-being, often substituted with terms such as “happiness”, “human development”, “living standards”, “quality of life,” or “human welfare”, is critical to promoting good lives and a good society (Lamb & Steinberger, 2017). For example, good health and well-being have been identified by the United Nations as Goal Three of 17 Sustainable Development Goals (United Nations General Assembly, 2015). Likewise, the Organisation for Economic and Co-operation Development (OECD) biennially publishes an account of well-being indicators for individual countries (OECD, 2015). Experiences of well-being differ in relation to many factors; for example, the different settings that have an impact on health experiences (Fleuret & Atkinson, 2007). It is in this context that work as a key life pursuit that consumes a “third of adult life” (WHO, 1995, p.2) and therefore critical to both individual and societal well-being (Basińska-Zych & Springer, 2017; Harter et al., 2003) has emerged as a critical context to further enhance understanding of the well-being construct. It is also argued that workplace well-being has an impact on job performance and organisational productivity (Baptiste, 2008; Danna & Griffin, 1999; Harter & Schmidt, 2006; Harter et al., 2003; Ravenswood, 2011; Slemp et al., 2015; Sears et al., 2013; Truss et al., 2013; Warr, 1999). As a result, organisations that invest deeply in the well-being of their workforce experience higher productivity and performance (Bryson, et al., 2014; Edgar et al., 2015; Kowalski & Loretto, 2017; Warr, 2002, 2007; Warr & Nielsen, 2018).

The significance of work to life, as well as the intertwined relationship between productivity and job performance justifies the examination of workplace well-being in aged residential care (ARC). Global ageing trends have created unprecedented demand for ARC services (Cangiano & Shutes, 2010; Hussein & Manthorpe, 2005; Lafortune & Balestat, 2007; Ravenswood et al., 2017; Stone & Harahan, 2010). However, it is well documented that globally, the ARC sector suffers from labour shortages caused by, inter alia, poor working conditions including the gendered, emotionally taxing nature of highly feminised aged care jobs (Brotheridge & Grandey, 2002; Hussein, 2017; 2018; Islam et al., 2017). These poor conditions of work have discouraged local-born employees from offering their labour services to the aged care sector, resulting in a skills shortage and an aged care deficit (Badkar, 2009; Badkar et al., 2009; Badkar & Manning, 2009; Clarke & Ravenswood, 2019; Kaine & Ravenswood, 2014; King et al. 2013; Lazonby, 2007; Martin & King, 2007; McGregor,

2012; Productivity Commission, 2011; Shannon & McKenzie-Green, 2016). The increase of the ageing population requiring care occurring in a context of labour shortages, has had significant impacts on ARC care services. For example, it has created an operational tension causing the needs of the worlds' ageing population to increasingly come under stress (Munkejord, 2017; Spencer et al., 2012; van Hooren, 2012). Additionally, it has impacted on the willingness and motivation of those already employed in ARC to continue offering their services (Hodgkin et al., 2017; King et al., 2013). For example, due to understaffing, ARC workers generally endure heavy workloads and other difficult working conditions (Kaine, 2012). A study conducted in the UK ARC sector found that the employees were over-stretched which impacted negatively on their work experiences and well-being resulting in high attrition and turnover rates (McGilton et al., 2014; Sizmur & Raleigh, 2015 Xiao et al., 2021). Therefore, a key challenge facing global health systems is how best to meet the health needs of an ageing population in a context of labour shortages (Bloom et al., 2015; Booth et al., 2007; Ogura & Jakovljevic, 2018; World Health Organization, 2016).
To address this labour shortage, most Western countries have progressively employed migrants, most of them women from developing countries (Baines et al., 2017; Cangiano et al., 2009; Cangiano & Shutes, 2010; Da Roit & Weicht, 2013; McGregor, 2012; Yeates, 2009). This study focuses on workplace well-being in a context of migrant aged care workers who are increasingly playing a critical role in New Zealand's ARC (Badkar et al., 2009; Howe et al., 2019; Ravenswood & Douglas, 2017). As discussed in the next section, the migrant care workers' participation in residential aged care demands further scrutiny to inform a deeper understanding of the intersection between workplace well-being and work experiences related to ARC working conditions such as, inter alia, pay levels, workload, and workplace relationships.

Why well-being and migrant care workers

One of the questions that has received a lot of attention is whether immigrants working in elderly care are worse off than their local born peers? (Jönson & Giertz, 2013). The wide consensus in well-being literature is that individual employee characteristics impact significantly on how employees experience work and ultimately their workplace well-being (Aloisio et al., 2018; Biggio & Cortese, 2013; Bryson et al., 2017). To this end, a study of workplace well-being must necessarily investigate aspects that shape the study subjects' experiences of low wages, visa status, workload, and workplace relationships, as well as their worldview of repugnance to care and lack of status as aged care workers. In this regard, several characteristics related to the migrant care workers' identity invites an examination of how those characteristics may be implicated

in workplace well-being. In the first place, generally the term ‘immigrant’ or ‘migrant’ is used pejoratively to refer to non-whites who migrate from less developed countries to the more developed parts of the world (Castles, 2010; Leinonen, 2012), whilst ‘white’ migrants from the West are referred to as ‘expatriates’ or ‘mobile professionals…’ (Fechter & Walsh, 2010, p.1197; see also Croucher, 2012; Davison & Shire, 2015; Leinonen, 2012; Lundström, 2014).

Therefore, several critical factors linked to their migrant identities capture the inherently disadvantaged and vulnerable position migrants find themselves in way before they start work in a host country. Notwithstanding the “many bright sides of migration” (Bobowik et al., 2015, p.189; see also Alegría et al., 2017), there is consensus in literature that migrants as a group of people, endure significant negative challenges both in the country of origin and in the host country (Boccagni, 2014; Moyce & Schenker, 2018; Shariff & Ghani, 2016). These challenges include exposure to poor living standards, poor labour market opportunities, and, on arrival in a host country, experiences of underemployment and various forms of discrimination (De Haas et al., 2019; King-Dejardin, 2019; Papadopoulos, 2017; Piore, 1979; Reid, 2012). It has been argued that the result of migration combined with migrant status, are often poor emotional/mental, physical and social health outcomes (Baron-Epel & Kaplan, 2009; García-Gómez & Oliva, 2009; Williams et al., 2008), depression (Fenta et al., 2004; Kiang et al., 2010), alienation and loneliness (Tartakovsky & Schwartz, 2001) and lower life satisfaction (Bartram, 2011; Safi, 2010). The irony is not lost, that although migrants share complex migration motivations, the search for decent work to secure stable livelihood opportunities is ordinarily the most important driver (Cummings et al., 2015; ILO, 2013; Piore, 1979; Valiūnienė, 2016).

Additionally, it is argued that the experiences of migrant workers are significantly affected by how they are treated by peers and supervisors (Harrison et al., 2018). As mostly racially different newcomers, they generally experience extreme social inequality, including differential treatment and lack of access to opportunities in the labour market (Galabuzi 2006). Additionally, they are often easy targets of xenophobia in the host country (Grove & Zwi, 2006; Grove & Zwi, 2006; Harisson et al., 2018). Due to migration and their migrant identity, they carry with them the intersecting vulnerabilities associated with people who leave their homeland to settle elsewhere, such as routine discrimination, exploitation and racism (Anderson, 2012; Atanackovic & Bourgeault, 2013; Cangiano & Shutes, 2010; Castaneda, 2017; Friedman & Saroglou, 2010; Harrison et al., 2018; Lowell et al., 2010; Moyce et al., 2016; Moyce & Schenker,

2018; Timonen & Doyle, 2010a; Walsh & O'Shea, 2010). These sharp racial differences, in addition to reduced co-worker support, deprive migrant employees the necessary support and friendship ties which in turn constrain their adaptation experiences in the new work environment (Farh et al., 2010). Ultimately, migrants are pushed to the periphery of workplace networks resulting in significant physical and psychological distress for them (Fang et al., 2015; Harrison et al., 2018).

It can therefore be argued that a critical defining aspect of the migrant workers is the migrant identity. However, a definitional problem confronts the study of migrant identity because much of the terminology in current use either is vague or has certain value judgements associated with the term (Yankholmes & McKercher,2020). Several studies whilst arguing that there is no single, universally accepted definition of identity note that constructions of identity are situational and continually fluid (Ryder et al., 2000; Weigert et al.,1986; Lindgren & Wåhlin, 2001; Twigger-Ross et al., 2003). The theory of narrative identity argues that individuals construct their identity by integrating their diverse and conflicting life experiences into an evolving yet continuous narration that provides them with a sense of direction regarding their life trajectory (McAdams, 2018; Somers, 1994). The concept of identity entails distinctiveness and suggest that "… who we are, or who we are seen to be, can matter enormously" (Jenkins, 2014, p.1). Phinney's (1990, 2003) study found two factors that explain migrant identity: an identity with respect to a culture of origin and an identity related to the host society. These two aspects show that all aspects of identity have place related implications (Breakwell's (1986; 1992; Twigger-Ross, & Uzzell, 1996). As a result, there is increasing awareness that place related identity is central to the understanding of migrant identity because of the migrants' concerns about belongingness and being accepted into the host country' dominant culture (Engbersen et al., 2013; Schwartz et al., 2006; Tadmor et al., 2009), and how this acceptance plays into the migrants' conceptions of their well-being (Smith & Silva, 2011) and maintenance of their self-concept (Twigger-Ross & Uzzell, 1996; Ryder et al., 2000).

From a social identity theory perspective, the identity is therefore a social construction whose external application or internal enactment bestows particular a position that represents an asset or an obstacle to integration into the host community (Goffman, 1969; 1959; McAreavey, 2017). Migrant identity therefore is defined as a social construction that is shaped 'externally and internally' (Mead 1934 [1974] p.164) by the migrant's largely poor individual pre-migration socio-economic circumstances, host country restrictive migration and visa policies, everyday encounters and experiences

with the host country's labour market requirements and work place dynamics - all which produce precariousness and a sense of lack of belongingness in the migrants' lives leading to individual behaviours and actions that are tied to workplace well-being outcomes. Therefore, several factors combine to distinguish and shape the migrant identity, for example, holding a temporary visa, race, foreign origin, language, skin colour, ethnicity, gender, social class, and economic, religious or political refugee status (Benson, 2006; Gordon, 1964; Netto et al., 2018; Portes, 1999). The factors that characterise migrant identity such as the migrants' poor socio-economic backgrounds, temporary legal status, or temporary job holders, race, country of origin generally expose migrants to multiple forms of stigmatisation and discrimination (Morosanu & Fox, 2013; Portes, 1999). Goffman (1963, p.15) defines stigma as an 'attribute that is deeply discrediting', an 'undesired differentness' that 'spoils' an individual's social identity and affects her sense of self-worth. These factors of migrant identity play a pivotal role in migrants securing vulnerable and precarious employment such as aged care jobs where the migrants are generally exploited and discriminated against (Anderson et al., 2006; Creese & Wiebe, 2009; McKay et al., 2009; Shutes, 2012; Valentine, 2010). Vulnerable jobs are typically insecure, temporary and low paid with long and irregular working hours, and generally poor conditions of work (Jayaweera & Anderson, 2008).

One of the critical defining features of the migrant identity is captured in the concept of migrant status. On arrival in the host country, García (2017) argued that the migrant status is a double-edged sword. On the one hand, it enables the migrants to receive rights that are specific to their migrant identity. On the other hand, the migrant status is also used to deny some rights which are only for local-born employees. In turn, this ultimately achieves to differentiate them from local domestic citizens and local-born workers (García, 2017). This "otherness" associated with the migrant identities seems central to an understanding of migrant workers' workplace well-being (Muhr, 2008). Therefore, the creation of a migrant identity limits the structures and networks from which migrants may draw resources and in so doing reduces the possibilities for positive personal development due to migration.

Another significant aspect of the migrant's identities relates to the feminisation of migration and aged care, especially in relation to the employment challenges experienced by skilled migrant women (Dustmann et al.,2013; Gündüz, 2013; Hochschild, 2000a, 200b; King-Dejardin, 2019; Wojczewski et al., 2015; Yeates, 2004). In addition to experiences of the stress of being separated from their children and

practicing “transnational motherhood’ due to migration motherhood” (Dreby, 2009; Fresnoza-Flot, 2009; Hondagneu-Sotelo & Avila, 1997; Hochschild, 2000a; ILO, 2011; Menjívar et al., 2016; Menjivar & Abrego 2009), they also endure work-related challenges more specific to their gender identity, such as pay disparities and undervaluation of their input (Charlesworth & Heap, 2020; Heron, et al., 2017; Leuze & Strauß, 2016; Ravenswood & Harris, 2016).

One of the aims of this study is to emerge with recommendations that can improve the management of migrant workers. This is more likely to be achieved when the most significant aspects that impact their workplace well-being are isolated and examined. Previous research has advocated for the incorporation of ideology in scientific research (Greenwood & Van Buren III, 2017). It is generally agreed that globally, neoliberalism is the dominant ideology structuring business, work, and life (Braedley & Luxton, 2010; Harvey, 2005; Misra et al., 2006; Morgan, 2015). The role of neoliberalism in shaping the trajectory of ARC, especially with respect to resource provision, is increasingly being acknowledged (Mercille, 2018). It therefore seems logical that neoliberal influences on workplace well-being are examined if, as is the case in this study, one of the aims is to generate recommendations that contribute to improvement in workplace well-being in a context of increased migrant care worker participation in residential aged care.

It is also worth repeating that migrants’ participation in the delivery of aged care services in Western nations is happening within the backdrop of an aged care deficit (King, et al., 2013), that among other factors, is the result of poor aged care work’s social standing or image (Vernooij-Dassen et al., 2009) and several poor working conditions that have turned away local-born employees from joining the sector (Bednarik et al., 2013; Hussein & Manthorpe 2014; Redfoot & Houser, 2005; Walsh & Shutes, 2013a, 2013b). Evidence exists that neoliberalism is heavily implicated in some of these poor ARC work conditions (Crowley & Hodson, 2014; Polivka & Luo, 2019). As Hart et al. (2019) have argued, “a sustained shift towards a governing logic of consumers and markets has seen employment conditions eroded within aged care” (p.2).

This preceding brief discussion therefore suggests that generally, migrants who work in ARC appear to enter a new work environment that, notwithstanding its several opportunities, is replete with significant challenges that have a huge potential to

influence their well-being. Building on this discussion, the following section explains the specific research gap that this study addresses.

Problem statement

Internationally, the increased participation of migrants as care workers has received significant academic scrutiny highlighting the challenges experienced by ARC providers (Anderson, 2012; Atanackovic & Bourgeault, 2013; Bourgeault, et al., 2010; Cangiano & Shutes, 2010; Goel & Penman, 2015; Ho & Chiang, 2015; Spencer et al., 2012; Stevens et al., 2012; Stone, 2016; Timonen & Doyle, 2010a, 2010b; Walsh O'shea & O'Shea, 2010). As previously mentioned, evidence indicates that some migrants "suffer from a perfect storm of otherness" at work (Muhr, 2008, see also Huang et al., 2012) which ultimately leads them into not only "3D" or "dirty, dangerous and "dull" work, but also work that is dominated by exploitative relationships, as well as work that is incommensurate with their qualifications and previous training (Brooks & Simpson, 2013; Holgate, 2005; MacKenzie & Forde, 2009).

In the context of New Zealand, there is also growing research on the aged care sector, focussing on a diverse range of issues, such as employee participation, productivity, well-being and working conditions of aged-care employees in diverse work settings (Badkar, 2009; Douglas & Ravenswood, 2019a; Ravenswood, 2011; Kiata et al., 2005; Markey et al., 2015; Ravenswood et al., 2017). Some of the studies have explored gender issues in the aged care workplace (Ravenswood & Markey, 2018). Other New Zealand-based studies provide evidence of the increased participation of migrants in the aged care sector (Badkar et al., 2009; Cangiano & Shutes, 2010; Grant Thornton Report, 2010; Human Rights Commission, 2012; Lovelock & Martin, 2016; Meagher, 2016). However, none of the extant studies have isolated the migrants' pre-migration circumstances or their post-migration work experiences to inform a better understanding of their workplace well-being.

It can be argued that the increased participation of migrants in the New Zealand ARC sector raises potential issues for migrants. It has already been observed that migrants that participate in the aged care sector experience several challenges unique to their migrant identity. For example, Lovelock & Martin (2016) documented the experience of Filipino migrant care workers in both institutional and home care settings in New Zealand. They found that "workers were vulnerable to exploitation; the workforce is largely feminised and stereotypical understandings of racial groups and national characteristics informed recruitment and the workplace experience" (p.379). Similarly, other New Zealand-based studies have acknowledged that migrant care workers

experience significant challenges, such as perceived racism and discrimination (see Cangiano & Shutes, 2010; Grant Thornton Report, 2010; Human Rights Commission, 2012; Meagher, 2016). Additionally, they face difficulties in renewing their visas. For example, McDougall's (2018) study found that care facilities that employed migrants on a temporary visa experienced increasing difficulties in recruiting and retaining them. The shift in employing migrants to address the labour shortage and aged care deficit poses important and pressing questions about the implications for workplace well-being and for those whom the migrant care workers care for (Dyer et al., 2008).

Understanding how workplace well-being intersects with migrants' work experiences is therefore important not only for the well-being of care workers but for recruitment and retention of the workforce, and in turn for quality of care and productivity (Hussein & Manthorpe, 2012). However, despite the increased participation of migrants in the New Zealand ARC sector combined with the empirical evidence of the relationship between well-being and workplace experiences, there is still a dearth of studies that examine the intersection between well-being and work experiences in a context of migrant care workers.

Study aims

Within the context of the preceding discussion, this study asks the question: What are the intersections between well-being and workplace experiences of migrant care workers in the New Zealand aged care sector? In this respect, this study aims to:

1. Contribute to our knowledge of migrant experiences and well-being.
2. Give a voice to migrant care workers whose voice has not been heard before.
3. Contribute to practice by suggesting ways to improve migrant care workers' working conditions.

Drawing on the tenets of critical theory, this study explores workplace well-being in relation to how migrant care workers ascribe meaning to the term well-being, to the different aspects of their work environment. In this respect, it is argued that good qualitative interviews should encourage exploration and discovery (Creswell & Poth, 2007) and avoid tunnel vision (Maxwell, 2005). To this end, three research sub-questions guide the achievement of these aims:

1. How does migrant identity impact migrant care workers' well-being?
2. How do work conditions affect migrant care workers' well-being?
3. How do workplace relationships affect migrant care workers' well-being?

These questions are built around the understanding that workplace well-being is a function of various factors such as working conditions (Moyce & Schenker, 2018) and workplace relationships between employees and their managers, co-workers, residents and relatives of the residents (Ball et al., 2009; Jones & Moyle, 2016; Nichols et al., 2015) and the policy environment within which aged care organisations operate. The mention of the identity of the subjects of this study (migrants), underscores the key role of identity in workplace well-being (De Genova, 2002) including the challenges migrants experience as they negotiate their "otherness" in the labour market and in the workplace (Yu, 2019).

Research Design

It is widely agreed that ontology and epistemology are key to how researchers investigate a research problem (Bradshaw et al., 2017; Iosifides, 2018; Marsh & Furlong, 2002). The focus of this study is well-being and ARC migrant workers' workplace experiences. The intention was to engage with the views of migrants – female and male – regarding their perceptions of the nexus between well-being and workplace experiences. It is partly due to this author's opposition to that view of men as having a monopoly on knowledge and reality that this study deliberately sought the views of both men and women about the intersection between workplace well-being and workplace experiences.

Traditionally:

> "…[the] representation of the world, like the world itself is the work of men; they describe it from their own point of view, which they confuse with absolute truth" (de Beauvoir et al., 1997, p.26).

The author's opposition to male representations of the world espouse the ontological belief that there is no single reality, but a multiplicity of realities (Hollinshead, 2004; Yilmaz, 2013). This ontological stance therefore had implications for epistemology or the knowledge-gathering process, including analysis of the data (Blaikie, 2000). As a result, the researcher used the in-depth face-to-face, semi-structured interview technique primarily, because it enabled a closer interaction with the participants (Alby & Fatigante, 2014). Notwithstanding the traditional power differential between researcher and researched, the study participants were treated as both interpreters and co-producers of meaningful knowledge (Kincheloe, 2005; Kincheloe & McLaren, 2008). To this end, 23 participants in the ARC sector across New Zealand were asked to share their views about their experiences with different workplace environment settings,

including their workplace relationships with managers, co-workers, residents and relatives of the residents.

Significance of the Study

This investigation is important, first purely for the sake of the well-being of the migrants, and, secondly, considering the growing concerns in the aged care sector where "unlicensed staff and health care assistants provide the bulk of resident personal care" (Hughes, 2020, p.3). More than a decade ago, Lazonby (2007) described the New Zealand aged care sector as "in the throes of considerable transition" to a workforce crisis (p.36). As a result, the significance of this thesis is also better captured by thinking about what it might mean to not investigate the well-being of the migrant care workers especially considering their visible role in age care delivery and the well documented linkages between well-being, job performance and organisational productivity (Baptiste, 2008; Danna & Griffin, 1999; Ravenswood, 2011; Slemp et al., 2015; Truss, et al., 2013; Warr, 1999). Research has already established that employees who experience poor workplace well-being may show a diverse range of forms of dysfunctional behaviours, such as being overly and uncharacteristically aggressive, violent, being absent, unproductive or make poor quality decisions (Howell et al., 2016; Neuman & Baron, 1997; Ramzy et al., 2018; Taris & Schaufeli, 2015). Such dysfunctional behaviours are unlikely to see care workers playing a positive role in the optimal health of their age care residents.

Therefore, from a practice perspective, stakeholders such as the care workers, government and aged care facility managers are likely to benefit from a better understanding of how well-being intersects with workplace experiences. For example, the government and aged care sector managers may leverage the study findings to institute workplace changes to enhance well-being with a view to improving not only the well-being of the workers but their performance and organisational productivity. Academically, this thesis adds to the current theoretical and empirical perspectives of workplace well-being in a context of migrant care workers whose narratives remain both under-expressed and underexplored. The study is also personally significant considering my migrant identity, my gender and previous experiences in the New Zealand aged care sector as a migrant care worker. Therefore, personally as a migrant, understanding the well-being of individuals in the work setting where they spend most of their adult life, is not only a useful academic exercise, but an emancipating practical endeavour (see Greenberg et al., 2003).

Organisation of the Thesis

This chapter has provided the background of the study, including the research problem, the study aims and research design. The remaining chapters are organised as follows. The review extends the well-being literature by examining several thematic strands related to workplace well-being. First, well-being is conceptualised as an amalgam of physical, social, psychological/emotional aspects of the work environment. Work environment factors critical to workplace well-being include the precarious nature of aged care jobs as well as conditions of work. The various forms of taint are examined – physical, moral, emotional and social that is associated with aged care work and the implications for workplace well-being. Although extant theoretical well-being models offer significant insights into the intersection between workplace well-being and workplace experience, it is argued that these theoretical models have drawbacks when applied to workplace well-being in an ARC and migrant care workers' context. Chapter Two concludes by arguing that a more nuanced and insightful understanding of workplace well-being is more likely to emerge from analyses that go beyond the role of well-being factors within the control of specific aged care organisations and individual employees. In this respect, Chapter Three makes a case about the importance of examining the potential well-being influence of two factors that have hitherto remained peripheral in the study of workplace well-being in the context of migrants and New Zealand's ARC. The first factor is the migrant identities which are defined by precariousness emanating from aspects such as race, lack of qualifications deemed appropriate in the labour market, and temporariness due to the temporary visas the migrants hold. The second factor is the neoliberal business environment within which aged care organisations operate and its influences on employment relationships and other aspects of the work environment that impact migrant care workers' workplace well-being. Neoliberalism is implicated in migration and feminisation of both migration and care. Migrants are a cheap source of labour. Migrants find themselves in a labour market environment that is largely influenced by the neoliberal principles of surplus value creation, marketisation of care and producing more with few inputs (Harvey, 2005; Lewis et al., 2015). As a result, neoliberalism contributes to the structural marginalisation of migrants with far reaching implications for their workplace well-being. In Chapter Four, the analysis focuses on the key characteristics of the New Zealand ARC sector. The examination of the New Zealand ARC context, and labour supply issues are situated within the global care deficit phenomenon and a neoliberal business policy environment that is increasingly shaping care regimes and subsequent employee management practices that influence workplace well-being. The analysis

reveals the presence of mostly privately owned, for-profit, and not-for-profit aged care service providers.

The Methodology Chapter Five discusses the research design including how the critical feminist ontological and epistemological premises of the study influence on the conduct of this study. The attraction of the critical feminist paradigm is in the ontology of the existence of multiple realities. This in turn influenced the epistemological knowledge gathering process that privileged a close interaction between the researcher and the researched in the co-creation of knowledge. The chapter explains the details of the field research and approaches to data analysis.

The findings drawn from migrant care workers in different aged care facilities in cities across New Zealand's North and South Islands are presented in Chapter Six. Central to how the participants make sense of their workplace well-being is the concept of the quality of the work environment. The findings show that several factors, including migrant identities and precarious migrant agency, combined with poor aged care practices and conditions of work, has a positive and negative impact on the physical, social and psychological well-being of the participants.

Building on the literature review, Chapter Seven discusses the field research findings presented in the previous chapter. The discussion of the findings centres on three factors that play a significant role in the migrant care workers' well-being. These are the factors (generally negative socio-economic, religious and political ones) accounting for the migrants' decision to emigrate. These impact the migrants' labour market experiences in terms of which jobs to take or not. The second factor is the migrant identities combined with their legal status that largely limits the labour market opportunities. This results in them taking up low-paid low-entry jobs, such as aged care work. The third discussion point is the nature of the actual workplace experiences, including the nature of the job, work conditions and workplace relationships. The final discussion centres on how the neoliberal business policy environment influences ARC working conditions that have an impact on well-being.

Chapter Eight, the last chapter of this study, examines the findings and their contribution to the literature on workplace well-being. One of the biggest contributions made to the well-being literature is the development of a new model that integrates various theoretical strands to inform a more comprehensive understanding of factors implicated in workplace well-being in an ARC and migrant care workers' context. The model captures the role of several factors that are critical to a nuanced understanding

of the nexus between well-being and work experiences in an ARC and migrant care workers' context.

Chapter 2: Workplace Well-Being Literature Review

> *"I get up every morning determined both to change the world and to have one hell of a good time. Sometimes, this makes planning the day difficult" (White, cited in Mick, 2006, p.1).*

Introduction

The previous chapter provided the background of the study by emphasising the literature strands that inform the examination of the interface between well-being and work conditions such as workload, remuneration, staffing, and relational experiences with the residents, co-workers, and supervisors. This chapter unpacks the well-being concept in greater detail by examining workplace factors germane to the aged care sector in relation to aspects of migrant identity that are implicated in migrants being employed in vulnerable aged care jobs. Additionally, four dimensions of workplace wellbeing in the context of migrant workers are discussed. These are physical, social, psychological/emotional, and spiritual wellbeing. Finally, this chapter extends the literature on workplace well-being by expanding the analysis of factors that influence workplace well-being beyond the generic work environment factors by including an analysis of aged care as dirty body work. This analysis leads to a discussion of the concept of taint in relation to its implications on workplace well-being.

The concept of well-being

The notion of well-being has a rich history stretching back to Aristotle and Epicurus' attempts to understand aspects that make a good society (La Placa et al., 2013; Ryan & Deci, 2001). However, because it is an intangible construct that is often defined using disparate cultural lenses (Fattore et al., 2007); a single globally accepted definition of well-being remains elusive (Crivello et al., 2009; Dodge et al., 2012; Forgeard et al., 2011). Despite the presence of several well-being philosophies, mainstream research defines well-being via two complementary perspectives. The first is 'hedonic,' which views happiness and pleasure as critical human pursuits (Diener, 2018; Huta & Ryan, 2010; Ryff & Singer 2006; Sen, 2001; Smith, & Diekmann, 2017). The second is 'eudemonic,' which is concerned with self-actualisation and personal growth-related life goals (Ryan & Deci, 2001; Ryff & Keyes, 1995).

Hedonia as the pleasure-aspect of well-being relates to an individual's emotions (Huta & Ryan, 2010; Huta & Waterman, 2014; Rahmani et al., 2018). Hedonic well-being therefore concerns the balance of pleasure over pain (Biswas-Diener et al.,2009). These constructs that characterise hedonia are largely subjective because people tend to perceive them differently. Consequently, this subjective nature of these constructs

has led to hedonia being tied to what is commonly called subjective well-being (SWB) (Ryff, 1989; Ryff & Singer, 2008). SWB as "a broad category of phenomena that includes people's emotional responses, domain satisfactions, and global judgements of life satisfaction" (Diener, Suh & Oishi., 1999, p. 278) is therefore primarily considered to be a gauge of hedonic well-being (Deci & Ryan, 2008a; Waterman et al., 2010).

SWB is widely agreed to contain three aspects. These are the frequent experience of positive affect, the infrequent experience of negative affect, and positive cognitive evaluations of life satisfaction (Diener, 1984). SWB is also mostly understood as an outcome of the interconnections between the environment, human emotions, and human behaviour (Dienner et al.,1997). There is copious evidence that link environmental stimuli to emotions, and subsequent human action (Mehrabian & Russell, 1974a,1974b; Donovan & Rositter,1982; Donnovan, et al., 1994). In their seminal paper, Mehrabian & Russell (1974a) established that different element of the environment can cause emotional responses such as arousal, pleasure, and dominance. In turn, these emotional responses generate 'approach–avoidance behaviour' (Turley & Milliman, 2000).

Approach behaviour comprises all the positive behaviours of willing to stay for example, in an organisation; whereas avoidance behaviour is the opposite (Bakker, Van der Voordt et al., 2014; Mehrabian & Russell, 1974a, 1974b). Two types of stimuli trigger a person's senses leading to hedonia. These are (1) relaxation and comfort, or the physical and psychological state of felt energy; and (2) pleasure in experiencing positively perceived activities (Huta & Ryan, 2010). In the context of this study, this theory suggests that elements of the work environment will generate certain emotions in the employees, which in turn will either decrease or increase their hedonic well-being levels. This is in line with the WHO (1995) research, which found that "Conditions of work and the work environment may have either a positive or hazardous impact on health and well-being" (1995, p.1).

The second widely discussed popular well-being philosophical tradition is eudemonia: a classical Greek term for a good life (Diener, 1984; 2000). One of the proponents and founder of eudaimonic well-being is Aristotle (c. 384–c. 322 BCE). Aristotle criticised hedonic well-being as "vulgar" (Waterman, 1990). Aristotle proceeded to define eudaimonic well-being as more than being happy because it includes the actualization of the human potential (Waterman, 1990). In other words, eudaimonia is activity that is aligned with one's 'daimon' or what is considered worth having in life (Waterman, 1990). An underlying premise of the eudaimonic perspective is that individual's experience well-being when they are fulfilling their potential while contributing to the

greater good (McMahan & Estes, 2011a; Ryan & Deci, 2001). Therefore, whilst on one hand hedonism views well-being from a pleasure or happiness perspective, on the other hand, eudaimonism asserts that well-being cannot be limited to mere happiness and "lies instead in the actualisation of human potentials ..." (Ryan & Deci, 2001, p. 143). As a result, the eudaimonia focus is more future-oriented with a focus on personal growth, achievement, purpose in life, meaning, pursuing self-concordant goals, self-actualization, and virtue (Sheldon & Elliot, 1999; Waterman, Schwartz, & Conti, 2008; Huta & Waterman, 2014). Eudaimonic approaches are linked to the satisfaction of basic human needs for competence, autonomy, relatedness, and self-acceptance (Huta & Ryan, 2010). The eudaimonic tradition also concentrates on positive psychological functioning, called flourishing by Keyes (2002; 2005), rather than feelings of personal pleasure.

The conceptualisation of well-being as a by-product of experiences that are objectively good for the person has resulted in research inspired by eudaimonic philosophy being associated with the concept of objective well-being (OWB) (Ryff 1989a). OWB is concerned with tangible qualities that define a person's circumstances (Ryff 1989a; 1989b; Ryff & Singer, 1998). This may include a person's socio-economic conditions, such as income, level of education and the absence of illness (Schueller & Seligman, 2010). The objective approach therefore defines well-being in terms of quality of life indicators such as material resources (e.g., income, food, housing) and social attributes (education, health, political voice, social networks, and connections) (Western & Tomaszewski, 2016). In essence, objective well-being is defined by congruence between one's life activities and one's deeply held values (Waterman, 1993).

Building on these conceptualisations of eudemonic well-being, it can be argued that eudaimonia at work is about employees' experiences that help one to grow as well as make one to develop a sense of purpose especially in relation the contribution of the job to the larger community (McMahan & Estes, 2011a, 2011b; Ryff & Singer, 1998). Fisher (2013) argues that several organisational behaviour constructs such as job involvement, work engagement, thriving, flow and intrinsic motivation, meaning in work, and calling at work display at least partial overlap with eudaimonic well-being. Job involvement is the opposite of alienation or meaninglessness (Brown, 1996), These eudaimonic concerns about valuing growth; seeking challenge; seeking personal excellence; and wanting to serve a higher and meaningful purpose are important in informing the discussion of how migrant care workers relate their experiences of performing a low status job to their well-being. Several studies have concluded that

hedonia and eudaimonia occupy both overlapping and distinct niches within a complete picture of well-being, and their combination may be associated with the greatest well-being (Anić & Tončić, 2013; Huta & Ryan, 2010; Peterson et al., 2005).

The literature therefore present hedonism and eudaimonia as central concepts of well-being. At the same time, the overlap and distinction between these two forms of well-being continues to be a topic of ongoing debate (Biswas-Diener et al., 2009; Huta & Waterman, 2014; Deci & Ryan,2006; Kashdan et al., 2008; Keyes & Annas, 2009; Keyes et al., 2002). For example, Kashdan et al., (2008), have argued that the distinction between the two is rooted in philosophy and does not necessarily translate well to science and evidence. They suggest that hedonic and eudaimonic well-being overlaps conceptually but represents psychological mechanisms that operate together.

There is no question that this two-model distinction has intellectual appeal, but this study's view is that this is not the most useful way of framing research in workplace well-being in a context of migrants and the aged care sector. As a result, workplace well-being conceptualisations in this study will be informed by both hedonic and eudaimonic perspectives. A hedonic and eudaimonic conceptualisation of well-being suggest that well-being is about feeling good and functioning well; the experience of positive emotions such as happiness and contentment as well as the development of one's potential, having some control over one's life, having a sense of purpose, and experiencing positive relationships ((Chartered Institute of Personnel and Development (CIPD), 2007; Huppert, 2009; Diener, Lucas and Oishi, 2002; Ruggeri et al., 2020).

These hedonic and eudaimonic conceptualisation of well-being are central to the well-being definition developed for this study of workplace well-being and migrant care workers. However, because migrants share unique labour market experiences in the host country, a definition of workplace well-being must necessarily show awareness and sensitivity to this reality in relation to impacts on workplace well-being. Additionally, a definition of wellbeing in a context of care must recognise the precarious characteristics of care workers as a disproportionately female, racialised, and immigrant workforce often lead to labour market disadvantages (Duffy et al., 2013; Hochschild, 2012; Folbre, 2012). The literature consensus is that the nature of lower status forms of care work devalues earnings resulting in such work often disproportionately precarious and part time (Barron & West, 2013).The literature agrees that migrant workers are among the most vulnerable members of society often engaged in precarious employment, for example, jobs that are hazardous to their health, working for less pay, for longer hours, and in worse conditions than do non-migrants, subject to, abuse and, and other poor condition of work that lead to poor

health outcomes (ILO, 2015c; Moyce & Schenker, 2018, Quandt et al., 2013). Migrant workers are at increased risk of precarious employment arrangements in addition to being subject to discrimination and exploitation, which ultimately adversely impact on mental wellbeing (Wickramasekara, 2008., Agudelo-Suárez et al., 2009, Gray et al.,2021). Van Hooren's study (2012) established that migrant employees work longer hours and do more night shifts than their native-born peers in elder care. Migrant workers also show an increase in the incidence of serious, psychotic, anxiety, and post-traumatic disorders due to a series of socio-environmental variables, such as loss of social status, and separations from the family (Mucci et al., 2019b; Tarsitani et al.,2016). Therefore, in this study, workplace well-being refers to the work-related physical, psychological/emotional, social and spiritual aspects and their part in enabling or disenabling vulnerable migrants in precarious employment to physically, socially, psychologically/emotionally, and spiritually flourish and achieve their full potential for the benefit of themselves and their organisation.

Workplace well-being

Work may be related to well-being because it provides a source of "positive social relationships", "a sense of identity and meaning" and an "optimal level of pleasurable stimulation" (Diener et al. 1999, p. 293). In defining workplace well-being, several studies are informed by two concepts: 'context-free' well-being in terms of life (Warr & Nielsen, 2018) and 'quality of life' (WHO, 1996). Context-free well-being is usually captured in the apparent tautology in the constructs of 'health' and 'well-being' in the WHO's (1948) definition of health as 'a state of complete physical, psychological and social well-being and not merely the absence of disease or infirmity' (p.1).

Similarly, the definition of quality of life emphasises the three dimensions of well-being: physical, social, and psychological health (WHO, 1996). The two concepts of 'health' and 'quality of life' are therefore important in understanding how management researchers have approached the study of workplace well-being. For example, the widely held consensus is that on average a third of an individual's waking hours are spent at work (Batt, 2009; Conrad, 1988; Quirk et al., 2018; Svane et al., 2019). This clearly suggests that employee well-being is greatly influenced by the time spent at the workplace, the tasks performed there, and the work environment (Adams, 2019; Harvard University T.H. Chan School of Public Health, 2016; Nilsen, 2016). Several management scholars have therefore relied on this inexorable relationship between work and personal life in addition to the World Health Organisation's (WHO) definitions of 'health' and 'quality of life' to shape their conceptualisations of the multidimensional concept of workplace well-being. For example, Grawitch et al. (2006, p. 134) argue that workplace well-being encompasses "…physical health, mental health, stress,

motivation, commitment, job satisfaction, morale, and climate" (p. 134), whilst Grant et al. (2007) define it as "the overall quality of an employee's experience and functioning at work" (p.52). Similarly, the European Union Working Conditions Observatory's (EWCO) well-being definition emphasises all the aspects of work life, including occupational health and safety and how employees feel about the totality of the work environment (ILO, n.d.). Central to all these definitions are terms such as 'physical health', 'psychological state,' and 'social relationships' (Rees et al., 2010; Stratham & Chase, 2010). Some studies present workplace well-being as an intersecting triumvirate, or tripod of psychological/emotional, physical, and social functioning (Gasper, 2007; McMahan & Renken, 2011; McMahan & Estes, 2011a; Suh & Punnett, 2021; Tsukamoto et al., 2015) whilst others add and spiritual dimensions (Bennett et al., 2017; Fagley & Adler, 2012; Pawar, 2016; Walia, 2018).

It is argued that spirituality enables people to worry less, to let go and live in the present moment (Ghaderi et al., 2018; Jafari 2010; Puchalski, 2001). Classical definitions of spirituality have been criticised for defining spiritual well-being by narrowly focussing on the religious, ecclesiastical, or matters concerned with the soul (Fisher et al.,2000). Several studies have argued that spirituality covers all aspects of human life and experiences (Muldoon & King, 1995). "Spiritual well-being is the affirmation of life in a relationship with God, self, community and environment that nurtures and celebrates wholeness" (Ellison, 1983, p. 331). In the same vein, workplace spirituality has been defined as "the recognition that employees have an inner life that nourishes and is nourished by meaningful work that takes place in the context of community" (Ashmos & Duchon, 2000, p. 137).

Most of the studies argue that spirituality is characterised by five domains. These are meaning, value, transcendence, connecting with oneself, others, God/supreme power and the environment, and becoming (the growth and progress in life) (Hematti et al., 2015; Knapik et al., 20102). These domains of spiritual well-being appear important to migrants who have moved away from their homelands to start new relationships with new environments, people and workplace processes and methods and are generally subject to exploitation and discrimination in the host countries se countries (Kalleberg, 2018). It is not far-fetched to argue that migrant workers supplanted from their home environments will be on the lookout for something that can give them a sense of usefulness and recognition in a new environment. Meaningful work, enriching connections with co-workers and alignment between their core spiritual values and organisation values are therefore critical to their spiritual well-being (Milliman et al., 2003; Petchsawang & Duchon, 2009).

However, before conducting a detailed analysis of factors that have an impact on the physical, psychological/emotional, social and spiritual well-being elements in the context of health care in general, and ARC in particular, it is important to briefly examine the contributions and limitations of some of the current theoretical approaches to the study of well-being. To this end, one of the most discussed concepts in terms of its workplace well-being impacts is the "quality of the work environment", which encompasses among other things, leadership and management practices, workload, and the quality of relationships with co-workers (Deci & Ryan, 2008; Hvid & Hasle, 2003; Knudsen et al., 2011; Kuoppala et al., 2008; Stansfeld & Candy, 2006). It is argued that well-being is the main concern of the quality of the work environment perspective (Markey et al., 2012).

Although some argue that the quality of the work environment is not necessarily concerned about individual employees or job characteristics (Cottini et al., 2009; Sell & Cleal, 2011), other studies argue that the "quality of the work environment" includes the "psycho-social work environment". This indicates how job demands and attributes, including perceptions of job satisfaction and workplace stress and other workplace conditions, have an impact on workplace well-being (Knudsen et al., 2011; Macky & Boxall, 2008; Markey et al., 2012). Other aspects of the quality of the environment that are directly connected to well-being include work-life satisfaction (Batiste, 2008), social relationships and positive experiences at work (Fisher, 2014), meaningful and rewarding work (Dik et al., 2013) and "optimal experience and functioning" (Ryan and & Deci, 2001, p.141, see also Keyes, 1998). The importance of the work environment to well-being is underscored by its characterisation as either "toxic" or "conducive" (Kyko, 2005).

Additionally, aspects of the quality of the work environment have been identified in extant well-being theoretical models as impactful to the quality of the employees' physical, spiritual, social and psychological/emotional well-being. The most prominent models include Hackman and Oldham's (1976) job characteristics model; Harrison's (1978) person-environment fit theory (P-E fit); Karasek & Theorell's (1990) job demand-job control model, and the extended Job Demand-Control-Support (JDCS) model (Johnson & Hall, 1988). The other models are Warr's (2013) 'Vitamin model;' Siegrist's (1996) effort–reward imbalance model (ERI); Danna &Griffin's (1999) 'A framework for organizing and directing future theory, research, and practice regarding health and well-being in the workplace" (p.360); and Guest's (2017) "HRM, Well-Being and the Employment Relationship, and Performance Model" (p.30). These models invariably implicate individual employees, management/supervisors and business owners in the

level of workplace well-being. For example, Hackman and Oldham (1976, p.256) identify five job characteristics, “skill variety, task identity, task significance, autonomy, and feedback” as being crucial to aspects of workplace well-being, such as employee satisfaction and experiencing work as meaningful (see also Di Fabio, Diener et al., 1999; 2017; Dik et al., 2013; Pratt & Ashforth, 2003; Slemp, et al., 2015). These five factors can be controlled by individual employees through job crafting and by managers who have sometimes been described as “architects of inequalities” (Grimshaw et al., 2017, p.12) for their role in determining job resources and employee engagement (Bakker & Demerouti, 2007; Harter et al., 2002) as well as various other aspects of the psychosocial work environment that impact well-being (Bakker & Demerouti, 2007; Elliott et al., 2012).

The preceding criticisms can also be extended to the Person-Environment (P-E) Fit theories (Harrison, 1978) which argue that well-being suffers when employees feel overwhelmed by environmental demands (Kristof-Brown et al., 2005). An argument could be made that the P-E fit conceptualisation of the ‘environments’ that influence well-being is too narrow because it is limited to mostly, internal organisational controllable work environment factors. This is also evident in the Job Demand-Job Control mode (Karasek & Theorell, 1990) and its expanded version, the Job Demands-Control-Support Model (JDC-S) (Johnson & Hall, 1988). It can be argued that the work environment factors identified in these models are critical to workplace well-being such as job roles and tasks, safe work practices, job design, performance monitoring, team leader support and job performance enabling. This enables resources to be largely influenced by managers and business owners (Cullen-Lester et al., 2016; Skakon et al., 2010). This also suggests that these factors can be improved through internal organisational mechanisms.

The emphasis on the role of factors internal to the organisation on workplace well-being is also apparent in Warr’s (2007a, 2007b, 2013) ‘Vitamin Model’. Through the model, Warr proposed that job-related well-being is influenced by job characteristics in the same way as vitamins influence physical health. The visual image created by Warr’s (2007a; 2007b; 2013) ‘Vitamins Model’ is that of managers operating under the guidance of the “goldilocks principle” applying “just the right amount” (O'Brien & Beehr, 2016) of “dosages” of workplace practices to influence all, for example, Seligman’s (2011) five PERMA well-being dimensions: positive emotions (P), engagement (E), relationships (R), meaning (M), and accomplishment (A). Likewise, Danna &Griffin (1999), Guest (2017), and Siegrist (1996) ascribe primacy to organisation and individual employee controllable factors to levels of workplace well-being. For example,

Guest (2017, p.31), identified “investing in employees, providing engaging work, positive social and physical environment, voice, and organisational support” as critical to levels of workplace well-being. As a result, for all the advantages of these extant well-being models, criticism must be levelled against them for being too “focussed on attributes of individuals at work rather than incorporating the work environment, the role of the regulatory environment or other external influences affecting employee well-being” (Ravenswood et al., 2017, p.1; see also Ravenswood, 2011).

As mentioned previously, in this study, workplace well-being refers to work-related physical, psychological/emotional, social and spiritual aspects of the work environment and their part in enabling or disenabling vulnerable employees in precarious jobs to physically, socially, psychologically/emotionally, and spiritually flourish and achieve their full potential for the benefit of themselves and their organisation. This definition captures the view that that migrant care workers occupy a position of potential ‘triple’ vulnerability in being migrant, from an ethnic minority, and female doing ‘women’s work’ (or male workers doing ‘women’s work’ (Christensen & Manthorpe, 2016; Crenshaw, 1991). There is widespread evidence that globally, migrant workers have higher rates of adverse occupational exposures and poor working conditions such as working for less pay, for longer hours, and in worse conditions than do non-migrants in addition to often being subject to human rights violations, abuse, human trafficking, and violence (ILO, 2015). Migrants often experience “Othering”, racialization, and other forms of discrimination (Syed, 2016). These experiences invariably lead to poorer health outcomes for migrants, in comparison to local born employees (Moyce & Schenker, 2018; Quandt et al., 2006).

Work environment in aged care.

The previous discussion has provided a foundation for the examination of aspects of the work environment within the aged care context that interface with the physical, psychological/emotional, social and spiritual aspects of workplace well-being. Additionally, in defining workplace wellbeing, there was recognition of the vulnerabilities and precarities associated with the migrant condition. Migrant workers are among the most vulnerable members of society often engaged in ‘3-D jobs - dirty, dangerous, and demanding (sometimes degrading or demeaning)’ jobs (Moyce & Shanker, 2018). Therefore, starting with the examination of conceptualisations of aged care as precarious work, this section also discusses key characteristics of ARC and their physical, social, physical/emotional and spiritual well-being impacts.

Aged care is characterised by a variety of insecure work patterns that have been linked to largely negative workplace well-being impacts (Kalleberg, 2018). The growth of the

aged care sector, as is the case with other service industries, has also seen a concomitant rise of insecure work patterns commonly referred to as “precarious work” (Kalleberg, 2011; Kalleberg & Vallas, 2018). Precarious work shares the characteristics of poor terms and conditions of work including poor training opportunities (Andreassi et al., 2014; Guest, 2017; Sorribes et al., 2021) and trust in management (Vanhala & Ahteela, 2011). Other precarious conditions of work include poor wages, temporary work, irregular hours, limited job protection, limited job control and autonomy, work overload, long hours, and exposure to various occupational health and safety (OHS) risks (Burgess & Connell, 2008; Kalleberg, 2000; 2009; Kalleberg & Hewison, 2013; Kalleberg & Vallas, 2018; McKay et al., 2012; Masterman-Smith & Pocock, 2008; Quinlan, 2012, 2015; Rodgers, 1989). Research has shown that these factors cause care workers to struggle with agency (King, 2012), poor morale (Cortis & Meagher, 2012), and perceptions of “low-status” and being considered “second class citizens” (Kessler et al., 2015, p. 10).

Some of the critical factors within the aged care sector that impact on workplace well-being emanate from the nature of health care as a twenty-four-hour daily service (Vermaak, et al., 2017). It is common in the healthcare sector to rely on nonstandard work schedules, such as night shifts, regular evening schedules, rotating and split shifts, irregular schedules, as well as on-call and casual forms of work that vary in line with demand (Costa, 2003; Liang et al., 2014; Monk & Folkard, 1992; Williams, 2008). It is widely agreed that these nonstandard work schedules significantly impact employees’ emotional/psychological well-being (Dall’Ora et al., 2015, 2016; Folkard, 2008; Leggat et al., 2013), and work-life balance (Aronsson et al., 2000; Bohle et al., 2011). Their impact depends on different factors, including whether the system involves a displacement of normal sleep time, whether an individual always works on the same shift, for example, evening or night, or rotates from one shift to another, as well as the speed and direction of rotation, shift length, and whether the shifts are consecutive (Folkard et al. 2007; Weale et al., 2019a, 2019b). Dayshifts are preferred by more workers, especially because they permit employees to work what are generally called “normal” working hours in comparison to a nightshift (Messenger, 2018; Shen & Dicker, 2008). Dayshift work provides employees with additional hours for recreation, allowing them to use the night as rest time (Harrington, 2001). Working day shifts therefore enables parents to spend more time with children and to better manage childcare duties (Golla & Vernon 2006). Therefore, working irregular day and night shifts may reduce the need for childcare for some as that ensures that there is always a parent available to attend to the needs of their children, which significantly reduces work-life conflict (Chandra, 2012; Dyer et al., 2011).

It is also widely agreed that shift work causes adverse psychosocial effects including poor work-life balance, reduced opportunities for participation in social life outside work, as well as contributing to less quality time between family members (Arlinghaus & Nachreiner,2016; Arlinghaus et al., 2019; Costa, 2003; Grady & McCarthy, 2008; Korabik et al., 2008; Pedersen & Lewis, 2012). Increased work family conflict due to nonstandard work schedules has been implicated in a decline in marital quality (Bulanda 2011; Jacobs & Gerson, 2004; Presser, 2000, 2003). There is also growing evidence showing that nonstandard employment of parents is linked to poor educational outcomes for their children (Jody, 2000; Premji, 2018; Rönkä et al., 2017) as well as the children's emotional and behavioural challenges (Bogen & Joshi, 2001; Strazdins et al., 2004). Additionally, since shift work is rarely limited to weekdays, the challenges experienced by families extend beyond finding childcare on weekends to include holiday planning as well as having to partake in selected social activities (Innstrand et al., 2009). There is also evidence that a nonstandard work schedule negatively impacts on the stability of marriages and family cohesion (Li et al., 2015; Pollmann-Schult & Li, 2020; Presser, 2005). In this respect, it has been found that women mostly suffer more than men from the increased work to family conflict arising from shift work than men (Tuttle & Garr, 2012).

A variation of shift work is casual and 'on call' in which an individual employee commits to being available for work when the organisation requires them (see ILO; 2016). On-call work is regarded as precarious work which impacts negatively, especially on employees' experiences of insecurity (Broughton et al., 2016; Campbell & Price, 2016; Grimshaw et al., 2016; Vosko et al., 2009). This is succinctly expressed by Bourdieu:

> "Casualization profoundly affects the person who suffers it: by making the whole future uncertain, it prevents all rational anticipation and… the basic belief and hope in the future that one needs in order to rebel, especially collectively, against present conditions, even the most intolerable" (1998, p.82).

Research has continued to refine and expand understanding of the complex interconnections between insecure and casual employment and health, pointing out especially their health-damaging effects (Devine et al., 2009; Kalleberg, 2018; Labonte & Schrecker, 2007; Malenfant et al., 2007). Notwithstanding some of the positives of casual work, such as work-family enrichment (Graves et al., 2007), in general, casual work is characterised by long working hours, and low predictability and control, both of which impact negatively on work-life balance compared to fulltime employees (Bohle et al., 2004). Studies have found that individual employee worries about job stability, job

opportunities and pay may compromise the ability of workers to maintain healthy sleep schedules (Grandner et al., 2015; Mai et al., 2018; Burgard & Alshire, 2009; Park et al., 2013; Virtanen et al., 2011). Several studies therefore argue that casual work is largely involuntary because most employees prefer predictable work hours (Campbell, 2018; Grimshaw et al., 2016; Pocock et al., 2004).

It has also been argued that the lack of job security has ripple effects as it affects other dimensions of life, such as insecurity about paying bills, buying food, maintaining honour and pride in one's community or household, causing (Allison, 2013)**.** This happens because job insecurity implies that there is uncertainty about work continuity (Adekiya, 2015; Kalleberg, 2018) and ultimately this causes the affected employee to live in a constant state of stress and anxiety (De Witte et al., 2015). It is also argued that employees in such situations struggle to develop a sense of organisational belonging (Findler et al., 2007; Le et al., 2018).As previously mentioned, it is widely agreed that psychological well-being, job satisfaction and physical strains are intertwined with job insecurity (Burchell, 1994).

There is also burgeoning literature that specifically addresses precarity in the context of aged care. For example, Gil's (2021) study on care worker profession in Portuguese nursing homes found prevalence of precarious working conditions, insufficient staffing, excessive workloads and long working hours, high rotation and insufficient skills. One of the visible markers of precarious aged care work is the undervaluation of care work especially because it is generally associated with women (Cortis, 2000; Meagher & Cortis, 2010). Several studies have demonstrated that women's work in providing care or nurturance is undervalued due to among other factors, pervasive cultural expectations that care work be performed out of altruism or duty, not for money, and to the idea that workers in caring occupations willingly accept lower pay for the opportunity to perform satisfying or mission driven work (Budig & Misra, 2008; England et al., 2002). King (2012) identified the emotional aspects of carework as contributing to its characterisations as precarious work. King's research demonstrated that the lack of relative autonomy; discouraged care workers from constructing themselves as professional carers providing quality care. At the same time, Cortis & Meagher (2012), provide insights into how the feminisation of the workforce has resulted in "the recognition given to the undervaluation of care work; the divergent interests of non-government sector employers and business associations; and strong contestation over who should pay, arising from the government's third-party role as purchaser of social and community services" (p.377). It is argued that low pay undermines Social and Community Services (SACS) workers' status and living standards, presents

disincentives to work in the sector, and undermines the capacity of government and non-government agencies to provide services that meet people's needs (Meagher & Cortis, 2010). Gil found that these conditions impacted not only on the quality of the care provided by these care workers, but also on their physical and mental health, and job satisfaction. These findings support Dyer et al.'s (2112) study where they found that the work life balance of migrants working in London's healthcare was impacted significantly by the nature of the precarious aspects of their care work.

Aged care and physical well-being

The preceding discussion on the precarious nature of ARC work has identified several work-related factors that impact physical, psychological and social well-being such as workload and occupational health risks including infectious diseases and physical abuse (Griffiths et al., 2018; Holst & Skär, 2017; Rees et al., 2010; Stratham & Chase, 2010). In this section, these three well-being elements are examined in greater detail with a focus on health care in general and ARC in particular.

Physical well-being refers to positive and negative workplace physiological evidence or the "the ability to perform physical activities and carry out social roles that are not hindered by physical limitations and experiences of bodily pain, and biological health indicators" (Capio et al., 2014, p.1). The effort-recovery theory (Meijman & Mulder, 1998), similar to the effort–reward imbalance (ERI) model (Siegrist, 1996), and Karasek's (1979) JDCS model, confirms that work is an essentially difficult activity that encompasses sustained effort which tends to impact negatively on workers' well-being in the form of fatigue and stress reactions. In a health care environment, physical well-being is mostly influenced by the various manual handling tasks associated with the frail patients that have limited ability for self-care including the quality of the physical environment within which this help is provided (Coman et al., 2018). Additionally, health care workers experience multiple forms of physical occupational hazards ranging from workplace violence, abuse or harassment, through to neglect when managers lack conviction to put in place as well as enforcing safety measures (Magnavita & Heponiemi, 2012; Malaspina et al., 2019; Morphet et al., 2019; Taylor & Rew, 2011).

A study by Sahraoui's (2019) found that most of these tasks are performed with insufficient, or poor-quality equipment because of managers' cost-cutting measures that have an impact on important supplies, such as incontinence pads and protective equipment, such as gloves (Sahraoui, 2019). This situation is exacerbated by several factors, including the increasing frailty of residents that makes them extremely functionally dependent on care workers (Davis & Kotowski, 2015; Kovach et al., 2010). Additionally, globally, ARC facilities have been found to generally suffer from

understaffing as well as under-resourcing (Harrington et al., 2012). This results in work overload, tight deadlines, work intensely, and a compromised ability to provide holistic relational residential care (Banerjee et al., 2015; Banerjee & Armstrong, 2015; Blackman et al., 2020; Sims-Gould et al., 2010). These poor conditions of work also result in "missed and delayed care" (Henderson et al., 2017; Kalisch, 2006; Ludlow, et al., 2019; Simmons et al., 2013). Additionally, the poor conditions of work partly explain why health care workers are susceptible to high risk of severe mental and physical stress and illness (Addati et al., 2018; Gass, 2004; Hung & Chaudhury, 2011; Portoghese et al., 2014).

Research has also found that heavy workloads, understaffing, shortage of time and long working hours do not only affect physical health in the form of physical exhaustion and job dissatisfaction, but may also impact on mental health in the form of anxiety, depression, stress and burnout (Al-Momani, 2008; Baptiste, 2009; Brannon et al., 2007; Burgess & Connell, 2008; Burgess et al., 2013; Danna & Griffin, 1999; Gosseries et al., 2012; Kalleberg & Vallas, 2018; Karasek & Theorell, 1990; Kowalski, et al., 2010; Mason et al., 2016; Sancassiani et al., 2015). The physical aspects of work are also key contributing risk factors for musculoskeletal complaints and ultimately "sickness absence" (Capponecchia et al., 2020; Collins et al., 2004; Coman et al., 2018; Darragh et al., 2015; Dasgupta, 2012; Engkvist et al., 1998; Hignett, 1996; Hoogendoorn et al., 2002; Trinkoff, 2006).

Aged care and social well-being

The second aspect is social well-being – or "social functioning" (Ryan & Deci, 2001). It is typically reflected in "interpersonal relations", "levels of support" and "perceived trust and fairness of treatment" (Guest, 2017, p.31). Jennings & Wasunna (2005) provides some insights into the social dimension of care work when they observe that;

> "All caregiving occurs in a psychological and social context that has shaped, and shapes the experiences of the participants in the caring practice. All caring, therefore, is at once intensely personal and inextricably social, symbolic, and meaningful. It is both deeply emotional and a rational, pragmatic, and practical endeavour. It is a practice that comprises certain fundamental moral virtues and human goods. It can be done well or badly; in a way that enriches or alienates, dignifies or humiliates either caregiver or the one cared for (p.444).

The quality of relationships between employees, co-workers and leaders, including the quality of social support within the workplace, are major elements of social well-being (Alagaraja, 2020; Fisher, 2014; Seligman, 2002; Spreitzer et al., 2005). Kazemi (2016)

describes occupational social well-being as an encompassing term that captures relational experiences and functioning at work.

Table 2.1 Aspects of social well-being

Author	**Aspects of social well-being**
Larson, 1993, p. 285	Social adjustment and social support
Kazemi, 2015, p.49 Keyes, 1998;	Social integration vs social isolation Social acceptance vs social rejection Social contribution vs social unproductivity/worthlessness Social actualisation vs social stagnation); Social coherence vs social meaninglessness
Keyes, 1998	Sense of belonging, interdependence
Cropanzano et al., 2001; Heffernan & Dundon, 2016; Seligman, 2002; Spreitzer et al., 2005	Quality workplace connections Organisational climate of trust
Putnam, 2001; Shier & Graham, 2011	Social capital and social networks
Caxaj & Gill, 2016; Mahar et al., 2014; Mendoza et al., 2017	Social connectedness
Fisher, 2014	Quality connections, satisfaction with co-workers High-quality exchange relationships with leaders, and social support
Berkman, et al., 2000; Rautenbach, 2015.	Social integration, social networks, 'social ties and social support'

Table 2.1 summarises selected authors' conceptualisations of social well-being. It has been found that social well-being is also significantly influenced by the psychosocial environment (Lock et al., 2018). In this respect, Siegrist & Marmot (2004) define the psychosocial environment as the "socio-structural range of opportunities that is available to an individual person to meet his or her needs of well-being, productivity and positive self-experience" (p. 1465). Seligman's (2002) work on positive psychology found that engagement is a key element needed to achieve more lasting happiness.

It is also argued that human social relationship aspects, such as trust, fairness and security, significantly influence workplace well-being (Ashleigh et al., 2012; Guest, 2017). Employees pay attention to whether they are treated fairly, because fairness is closely associated with psychological needs, including ''control, belonging, self-esteem

and meaningful existence'' (Cropanzano et al., 2001, p. 175). Most of these aspects are subsumed under the concept of perceived organisational support (POS) which refers to an employee's perception of the extent to which their organisation values their input (Spreitzer et al., 2005). The benefits of work therefore extend beyond income to encompass the other "less tangible benefits related to health, such as self-esteem, social engagement and social prestige or recognition" (Ronda-Perez et al., 2012, p.564).

Spirituality and workplace well-being

It is widely agreed that defining the term "workplace spirituality" precisely is difficult as it means different things to different people (Rathee & Rajain, 2020). At the same time, it is argued that work may be related to well-being because it provides a source of "positive social relationships", "a sense of identity and meaning" and an "optimal level of pleasurable stimulation" (Diener et al. 1999, p. 293). Relationships and the search for meaning in work are widely discussed as both social and spiritual aspects of the workplace (Ashforth & Pratt, 2003). According to McLaughlin (1998)

> "In today's highly competitive environment the best talent seeks out organisations that reflect their inner values and provide opportunities for personal development, and community service, not just bigger salaries" (1998,p.11).

Therefore, organizations that want to be competitive must necessarily offer a greater sense of meaning and purpose to their workforce. Several studies have explored the concept of spirit at work, spirituality at work, and workplace spirituality (e.g. Ashforth & Pratt, 2003; Ashmos & Duchon, 2000; Kinjerski & Skrypnek, 2004; Milliman et al., 2003; Mitroff & Denton, 1999; Sheep, 2004). However, due to the subjective nature of workplace spirituality, a shared understanding of the concept of workplace spirituality remains elusive. Ashmos & Duchon (2000) are generally recognised as having made the first attempt to measure spirituality in the context of work. Ashmos & Duchon's (2000) defined 'Spirituality at Work' as 'the recognition that employees have an inner life that nourishes and is nourished by meaningful work that takes place in the context of community' (p.137). Sheep's (2004) extended the study of spirituality and work by developing a 'Workplace Spirituality Person-Organization Fit Scale' which measured individual employees' attitudes towards the workplace as a place for personal and spiritual growth and expression, including their perception of the extent to which their workplace allows for such growth and expression.

At the same time, Assarroudi et al., (2011), believe that spiritual well-being is one of the most important factors in human health and healthy lifestyle in that it provides a coordinated and integrated connection between a person's internal forces (Assarroudi et al.,2011). It is also identified with features of stability in life, peace, harmony, and coordination, feeling close relationship with oneself, God, society, and the environment. In Sheep's (2006) view, workplace spirituality has a strong relevance to the well-being of individual employees, organizations and societies and has the potential to significantly improve the employees' quality of life. It has been found that a spiritually healthy person has a clear purpose in life and is able to reflect on the meaning of events (Wong, & Fry, 2013 Leider, 2015; Purdy & Dupey, 2005; White et al., 2011). Mirvis' (1997) idea of workplace spirituality includes notions of community and meaningful work whilst Mitroff & Denton (1999, p. 83) emphasise the basic feeling of being connected with one's complete self, others, and the entire universe. Meaning at work is derived from the nature of interactions the employee is engaged in, for example with other employees and their routine tasks, as well as the desire and motivation to be more involved in decisions about the tasks to be performed and whether the tasks being performed give meaning to their life (Albrecht, 2013; Ellison & Smith, 1991; Fouche et al., 2017; Hassan et al., 2016). Similarly, Hateley (1983) discussed spiritual health in terms of relationship to self, empathy in the community, and relationship with God, whilst Young (1984) identified the interrelatedness of body, mind, and spirit within the context of inner peace, and in terms of relationships with others and with nature.

Marques provide a more comprehensive definition of spirituality in the workplace;

> "an experience of interconnectedness and trust among those involved in a work process, engendered by individual goodwill; leading to the collective creation of a motivational organizational culture, epitomized by reciprocity and solidarity; and resulting in enhanced overall performance, which is ultimately translated in lasting organizational excellence (2005, p. 283).

Marques' (2005) definition above advances the idea that spirituality is the higher awareness that drives human beings to do well and entails realizations of being interconnected to all other living beings, showing respect to everyone and everything and recognizing that there is more to life than our material existence.in this regard, Duchon & Plowman (2005) identified three significant dimensions of workplace spirituality: engaging in work, community sense, and inner life connection (Duchon & Plowman, 2005; Marques et al., (2005).

Spirituality at work is also captured in the concept of 'calling'. For example, Fry's conceptualisation of spirituality (2003) included the notions of calling and membership which is similar to meaning and sense of community (Duchon & Plowman, 2005). Sense of community is about the individual employee's nature of interaction and relationships with co-workers and the community (Duchon & Plowman, 2005; Pratt & Ashforth, 2003).

From these studies it is clear that workplace spirituality has several dimensions, such as meaning in and at work, and sense of community (Chawala & Guda, 2010; Fry, 2003; Milliman et al., 2003; Mirvis,1997); spiritual identity and inner life (Beyer, 1999; Marques et al., 2005; Mitroff & Denton, 1999; Kinjerski & Skrypnek, 2004; 2006), notions of calling (Fry, 2003); experience of performing duties in a rewarding manner to all involved, providing ourselves, co-workers, managers and clients with feelings of trust, belonging, meaning, and fulfilment in all areas that are considered important toward the quality of our lives (Paloutzian & Ellison, 1982) and meaningful work (Ashmos & Duchon,2000; Kinjerski & Skrypnek, 2006). These different views of spirituality have given birth to four dimensions in the conceptualization of individual spirituality at work. These are engaging work (meaningful work), sense of community, and spiritual connection (inner life) (Kinjerski & Skrypnek, 2006; Mitroff & Denton, 1999). It is argued that meaning in work and belongingness to community nourishes the inner life of individuals and provides their work a spiritual dimension (Beyer, 1999).

Several aspects of spirituality emphasised in the definitions above have been captured in a model that was developed by Fisher (1998) and Fisher & Brumley (2008) and Gomez & Fisher, (2003), who described spiritual health as a fundamental dimension of people's overall health (i.e. physical, mental, emotional, social and vocational). Fisher & Brumley's (2008) model of spiritual health is made up of four domains which capture the idea that spiritual health reflects the extent to which people live in harmony within relationships as reflected in Figure 2.1 *Four domains of spiritual well-being*

Personal	Communal	Environmental	Transcendental
sense of identity	love of other people	connection with nature	personal relationship with the Divine/God
self-awareness	forgiveness toward others	awe at a breathtaking view	worship of the Creator
joy in life	trust between individuals	oneness with nature	oneness with God
inner peace	respect for others	harmony with the environment	peace with God
meaning in life	kindness toward other people	sense of 'magic' in the environment	prayer life

Figure 2.1 Four dimension of workplace spiritual well-being
Source: Fisher & Brumley, 2008, p.51).

The personal domain refers to how an individual's intra-relates with oneself with regards to meaning, purpose and values in life. It acknowledges that the human spirit employs self-awareness in its search for self-worth and identity. The second domain is expressed in the quality and depth of interpersonal relationships between self and others relating to morality, culture and religion, love, forgiveness, trust, hope and faith in humanity. The third domain (environmental) moves beyond care and nurture for the physical and biological to depict a sense of awe and wonder. It emphasises the notion of unity with the environment. The final domain (transcendental) describes the relationship of self with something or someone beyond the human level (i.e. ultimate concern, cosmic force, transcendent reality or God (Fisher et al., 2000).

The transcendental domain is commonly associated with conceptualisation of work as a calling or vocation that provides fulfilment to the employee. It is argued that "fulfilling work represents the core experience of well-being in the work context" (Allan et al., 2019, p.266). The Work as Calling Theory (WCT) (Duffy, Autin, England, et al., 2018; Duffy, Ryan et al., 2019) conceptualizes a calling as an approach to work that encompasses three aspects. These are; finding individual meaning and overall purpose in that work, helping others or contributing to the common good, and feeling a sense of being compelled (either internally or externally) toward that work. Different authors conceptualise calling in different ways. For example whilst Bellah et al.'s (1985) characterized a calling as something performed for its own sake or for the personal meaning and value associated with it, on the other hand, Wrzesniewski's (2003), argued that calling should have societal and not just personal significance and must also be "associated with the belief that the work contributes to the greater good and makes the world a better place" p.301).

It is argued that the notion of work as a personal calling views work that is done solely for economic or career advancement reasons as unlikely to inspire a sense of significance, purpose, or transcendent meaning (Bellah et al., 1985; Hall & Chandler, 2005; Dik & Duffy, 2009). Work as a calling assumes both personal and social significance (Pratt and Ashforth, 2003) and offers the "strongest" (Bellah et al., 1985, p.66), most "extreme" (Dobrow, 2004,p. b1), or "deepest" (Hall & Chandler, 2005,p.160) route to truly meaningful work. As a result, the importance of work has led many people to seek out careers that fulfil them in ways beyond traditional financial incentives (Block, 1993). This has led many individuals to place an emphasis on

passion overpay and has made certain types of work and a wider variety of organizations more attractive than in the past (Horton 2008).

As discussed previously, the idea of work as a calling emanates initially from the choice that many individuals make to enter into religious orders that required significant personal and financial sacrifices (Houston & Cartwright 2007; Word, 2008). The idea of work as a "calling" therefore enhances understanding of the way in which work connects to individuals outside of economic need. This is especially significant for migrants who are generally described as 'target earners' motivated by the economic benefits migration. From a well-being perspective this shows that work can fulfil workers in nonfinancial ways (Garg, 2017; Goforth, 2001). The meanings we attribute to work impacts on job satisfaction. Several studies have found that there is a positive relationship between workplace spirituality and job satisfaction (Van der Walt & De Klerk, 2014; Damon et al., 2003; Kinjerski & Skrypnek, 2004; Mitroff & Denton, 1999; Pratt & Ashforth, 2003). This is partly because many people that do, for example, low level poorly paid aged care job have a sense of "vocation" or "calling" to aged care that transcends poor remuneration and other poor terms and conditions of work (Hebson et al., 2015). As a result, constructs of calling and vocation have been used widely to imbue often poorly financially rewarded life and job roles with meaningfulness (Dik & Duffy, 2009; Dik et al., 2009). It is for this reason that aged care employees tend to report high subjective job satisfaction despite poor pay and poor conditions of work (Ashforth & Kreiner, 2013; Deery et al., 2019; Duffy et al., 2018; Hebson et al., 2015; Hussein et al., 2010).

It has also been established that those that are living out a calling tend to be the happiest, most committed, and most engaged employees (Dobrow &Tosti-Kharas, 2012; Douglass et al., 2016; Duffy, Autin, et al., 2015; Duffy et al., 2011; 2013; 2014; 2016; 2017; Duffy & Dik, 2013; Wrzesniewski, 2012; Yoon et al., 2017; Yoon et al., 2016). Dobrow & Tosti-Kharas (2011) defined calling as "a consuming, meaningful passion people experience toward a domain" (p.1005). This conceptualisation of calling depicts it as central to one's identity, promoting meaningful involvement within a particular work domain that benefits one's self, family, and/or society (Molloy & Foust, 2016). This is also reflected in Praskova et al.'s (2015) view of calling as a "mostly self-set, salient, higher order career goal, which generates meaning and purpose for the individual" (p. 93). This conceptualisation of calling is also aligned with Hall & Chandler's (2005), framing of calling as "what a person sees as his [sic] purpose in life" (p. 160).

Research has for example found that care workers in low status physically stained jobs derive job satisfaction from successfully imposing personal mastery on the dirtiest elements of the job (Bolton, 2005; Jervis, 2001; Stacey, 2005). As a result, constructs of calling and vocation have been used widely to imbue often poorly financially rewarded life and job roles with meaningfulness (Dik & Duffy, 2009; Dik et al., 2009). It is in this context that workplace well-being in this study is used with reference to work-related physical, psychological/emotional, social and spiritual aspects of the work environment and their part in enabling or disenabling vulnerable employees in precarious jobs to physically, socially, psychologically/emotionally, and spiritually flourish and achieve their full potential for the benefit of themselves and their organisation.

Aged care and psychological well-being

Another factor of the well-being concept – psychological well-being – refers to an individual's positive work experiences (Dagenais-Desmarais & Savoie, 2012) and is characterised by positive life perceptions and the presence of related positive emotions (Diener et al., 1999, 2018). These latter two concepts are also influenced by job satisfaction, job engagement and mental health (Danna & Griffin, 1999). It is also argued that higher levels of psychological well-being are generally associated with life and job satisfaction as well as having clarity about one's purpose in life, achieving "… personal growth, self-acceptance, life purpose, mastery, and positive relatedness" (Ryan & Deci, 2001, p. 146; also see Loon et al. 2019; Ryff 1989a; Ryff & Keyes 1995). In this respect, the eudaimonic well-being aspects of 'meaning in work' and 'meaning at work' (Pratt & Ashfort, 2003) are generally described as aspects of psychological well-being. Meaning *in* work, is related to the work role itself or doing something important and self-actualizing whilst 'meaning *at* work', encompasses identification with social entities, such as the organization or other individuals or collectives encountered in the workplace. The latter therefore include some aspects of social well-being (Fisher, 2014; Pratt & Ashforth, 2003; Steger, 2017; Steger et al., 2006). In their discussion of these two aspects of workplace meaning, Pratt and Ashforth (2003) suggest that both contribute to identity, and that when both are present, identities are integrated and transcendent meaning is experienced.

Within the workplace, the psychosocial work environment has been shown to be critical to social and mental well-being (Black 2008; Elliot et al., 2017).

Dagenais-Desmarais & Savoie (2012) identified interpersonal fit at work, thriving at work, feelings of competency at work, perceived recognition at work, and the desire for involvement at work as the five key workplace dimensions relevant to psychological

well-being. It is also widely agreed that people are driven by their innate need to control their environment including the desire for choice and independence in decision-making (Rodwell & Munro, 2013; Ryan et al., 2008; Ryff, 1989b).

Emotional well-being

One of the major psychological aspects of the care work is its emotional dimension. Whilst some aspects of the emotional dimensions of the work are captured in the psychological well-being domain, it may be necessary here to separate emotional well-being from psychological well-being. Emotional well-being is conceptualized as cognizance and control of feelings, as well as a realistic, affirmative, self-valuing and developmental view of the self, ability to deal with conflict and life circumstances, coping with stress and the maintenance of fulfilling relationships with others (Hall et al., 2016) Therefore a criticism could be made that this well-being tripod is limited in terms of informing a richer perspective of workplace well-being in the context of health care workers who experience significant emotional labour. Emotional labour refers to the requirement for individuals to manage or regulate their emotional expression, such as being required to be friendly towards customers in return for a wage (Brotheridge & Grandey, 2002; Diener and Suh, 2003; Diener et al., 2002; Diener et al.,1998; Grandey &Gabriel, 2015; Hochschild, 1983; Keyes, 1998; Kinman, 2009). Healthcare workers use emotional labour to create and cultivate bonds with patients or clients (Fouquereau et al., 2019), in particular when they wish to reduce patients' anxiety or need to perform an unpleasant procedure (Martínez-Iñigo et al., 2007).

Caregiving exposes careworkers to direct contact with human suffering and other severe occupational stressors or emotionally intense events, including suffering, fear, and death; McVicar, 2003; Ruotsalainen et al., 2015). As a result, care workers are required to constantly regulate not only their own emotions, but as well, the emotions of residents and relatives of the residents (Grandey & Gabriel, 2015). The tendency however is to see workers as passive enactors of emotional labour considering that ordinarily their behaviours must be in line with organisational expectations regardless of personal conflict experiences (Grandey, 2000). However, as Hochschild (1983) observed, that can lead to feelings of 'emotional fraudulence'. It is argued that inhibition of "true" emotions such as anger can result in psychological distress (Mauss & Gross, 2004), whilst fake friendliness can lead to depression, stress and other negative health outcomes (Bakker & Heuven, 2006; Grandey, 2003).

In the context of ARC, the well-being of care workers is affected by experiences of "emotional labour" (Hart et al., 2019; King, 2012; Vermaak et al., 2017). Emotional labour refers to the requirement for individuals to manage or regulate their emotional expression, such as being required to be friendly towards customers in return for a wage (Brotheridge & Grandey, 2002; Diener & Suh, 2003; Diener et al., 1998, 2002; Grandey & Gabriel, 2015; Hochschild, 1983; Keyes, 1998; Kinman, 2009). Research has observed that health care workers are required to constantly regulate not only their own emotions, but also the emotions of residents and relatives of the residents (Grandey & Gabriel, 2015). Most extant studies have therefore underscored the emotional difficulties experienced by ARC workers as they negotiate the social bonds arising from the intimate nature of their interactions with their residents (Anderson, 2007; Degiuli, 2007). Care workers often work very closely with their residents resulting in employees developing a strong sense of duty to their charges (Ayalon, 2009; Ayalon & Roziner, 2016; Baldassar et al., 2017; Cox & Narula, 2003; Marcella & Kelley, 2015; Timonen & Doyle, 2010a, 201b).

The relationships with relatives of residents are also an important aspect of the care workers' social, psychological and emotional well-being. Past studies found that conflicts with relatives of residents can result in caregiver depression (Chen et al., 2007), staff burnout and diminished job satisfaction (Abrahamson et al., 2009). The form of family involvement in the residents' lives has invited complex evaluations in extant literature (Bauer & Nay, 2003; Haesler, 2007). For example, Montgomery (1983) describes them positively as "health team members", whilst Nolan & Dellasega (1999) and Pillemer et al., (1998) describe families as "partners in care" (see also Harvath et al., 1994). Friedemann et al. (1997) described families as "advocates and protectors", whilst Rubin and Shuttleworth (1983) labels them "resources" (see also Twigg & Atkin, 1994). On the other hand, family involvement has also been labelled negatively as "a problem" (Safford, 1989) and "intruders" (Gubrium, 1991) as well as "disrupters" (Tickle & Hull, 1995) and "superseded carers" (Twigg & Atkin, 1994). The tendency, however, is to see workers as passive enactors of emotional labour, considering that managers expect their workplace behaviours to align with organisational expectations regardless of experiences of personal conflict (Grandey, 2000). However, as Hochschild (1983) observed, that can lead to feelings of "emotional fraudulence". It is argued that inhibition of 'true' emotions such as anger can result in psychological distress (Mauss & Gross, 2004), whilst fake friendliness can lead to depression, stress and other poor health outcomes (Bakker & Heuven, 2006; Grandey, 2003).

Aged care 'dirty body work' and well-being

The preceding sections have examined several aspects of the work environment that impact on physical, social, and psychological/ emotional well-being and spiritual well-being. At the same time, several studies agree that certain jobs including their roles and responsibilities can significantly affect employee well-being, subject to context and circumstances unique to the individual employees (Bakker & Demerouti, 2007; 2014; Birdsey et al., 2015; Hadgraft et al., 2016; Jones et al., 2017; Stiehl et al., 2019; Theorell et al., 2015). Current studies on workplace well-being have not examined the contribution of the nature of the aged care job to the care workers' well-being. There is extensive literature on the negative stereotyping of the aged care job emanating from the ageing process and the failings of the human body (Wahidin & Powell, 2003). Healthcare staffs generally succumb to the negative stereotype of associating old age with decay and deterioration (Koch & Webb, 1996; Herdman, 2002). According to Koch & Webb (1996) biomedical constructions of old age have implications for the way health care staff view both older people and the job of caring for them. In this respect, an aspect of aged care work that deserves further analysis because of its significant impact on employees' physical, psychological/ emotional, and social well-being is the nature of personal cares that have invited characterisations of the aged care job as 'dirty body work' (Anderson, 2000; Isaksen, 2002a, 2002b; Twigg, 1999). Hughes (1958) argued that dirty body work, such as aged care, is commonly linked to physical, social and moral taint (see also Ashforth & Kreinner, 1999). From the onset, judging work as dirty is a subjective social construction (Drew et al., 2007), and therefore "essentially a matter of perspective, not empirics" (Dick, 2005, p. 1368). Additionally, these socially constructed taint categories are not mutually exclusive (Ashforth & Kreiner, 1999; Meisenbach, 2010).

Central to the following discussion about the characterisation of aged care as dirty body work and its physical, social, spiritual and psychological impacts are two concepts. The first is the abject body, borrowed from Kristeva's (1982) concept of "abjection". The concept of abjection refers to "a realm of the impure, unclean and disorderly" and underlines representations of the aged body as an "object of disgust" (Gilleard & Higgs 2011, p.135). Generally, aged care work is considered an "inherently untidy experience" (Douglas, 1966) characterised by intimate bodily dirty work involving the "abject body" of the other (Karlsson & Gunnarsson, 2018; Kristeva, 1982) and performing tasks such as "bathing, toileting, and catheter management" (England & Dyck, 2011, p.206). As argued by Höpfl (2012), "contamination is about contact and contagion and the transference of social, physical or moral disease from one body to

another whether by touch or by exhalation" (2012, p.21). The second concept linked closely to the concept of the abject body that is central to an understanding of characterisation of aged care as work dealing with the abject body, is physical, moral, social and emotional taint (Ashforth & Kreiner, 1999; Rivera, 2018). The concept of taint emphasises that those who deal with the abject body risk literal and metaphorical contamination or pollution (Ashforth & Kreiner, 1999; Hughes, 1962). Previous studies discuss the concept of taint with reference to "biologisation" which captures the idea of the "dehumanization that involves the perception of others as infected and contagious – of physically tainted workers" (Valtorta et al., 2019b, p.3; see also Savage, 2007). As discussed in the following sections of this chapter, the aged care job, similar to other tainted occupations, may not only "lead to stigmatization but also elicit a dehumanizing image of workers" (Valtorta et al., 2019b, p.964). Additionally, whilst the concept of taint links well with the physical, social, and psychological/emotional aspects of workplace well-being– there is however, an additional form of taint - moral taint - that does not exactly fit any of these three well-being elements as the following discussion will show.

Physical taint of aged care work and well-being

Aged care workers are exposed to both physical and symbolic contamination because of their "intensive contacts with clientele and their bodily substances" (Jervis, 2001, p.89). From a perspective of taint, aged care is physically dirty work because of its "proximity to the (dys)functions and discharges of aged bodies and the notions of disease, decay and death associated with the idea of old age" (Hansen, 2016, p.1092, see also Dahle, 2005; Stacey, 2005; Twigg, 2000a). Physical taint arises when workers literally engage with hazardous dirty, tangibly offensive things such as waste matter, death or in the case of aged care, faecal and urinary incontinence and other bodily fluids such as vomit (Ashforth & Kreiner, 1999; Ashforth et al., 2008). Age care work can also be considered not only hazardous dirty work in so far as it is "… simply physically disgusting" (Hughes, 1951, p.319), but also in terms of physically polluting those that do the work. Research shows that health care workers in general are occupationally exposed to several chemical and biological hazards as a result of frequent exposure to bodily fluids and infectious agents or diseases (Markwell & Wainer, 2009; Quinn, et al, 2016; Walton & Rogers, 2017).

One of the most significant physical well-being impacts of aged care work is physical taint (Ashforth et al., 2007; Clarke & Ravenswood, 2019) or physical stigmatisation (Glaser & Strauss, 1965). This arises from the use of one's own body to provide care for another body (Twigg, 2000). Therefore, one of the sources of physical taint arises from the essentially physical nature of personal care, as well as the handling of

cleaning chemicals, bodily fluids and other human excretions. Using another body to complete all these body work tasks, may take a toll of the care worker in the form of visible physical marks such inflammation and musculoskeletal disorders (Collins et al., 2004; Davis & Kotowski, 2015). As argued by Zandy, the "'labouring body speaks the language of fatigue and frivolity, of sacrifice and shared experience" (2004 p.3). This is an interesting implication for the dignity of those who provide care, in that generally, as argued by McClintock (1995) the discourses of dirt and hygiene are used to define one's class. As a result, clean smooth hands are not only commonly seen as an indicator of "good breeding" and a certain financial standing but may indicate that one is not a manual worker (McClintock, 1995; Wolkowitz, 2001, 2002). It is therefore not surprising that some sections of society outsource manual dirty work because of the inherent risk of compromising the smoothness and integrity of body parts, such as their hands (McClintock, 1995; Wolkowitz, 2001). The "toll of dirty work" is indeed a "burden" that many people shoulder silently (Baran et al., 2012, p.597). The physical taint of age care work which violates the integrity of the body is therefore a "blemish on one's physical body" (Ashforth & Kreiner, 2014).

Moral taint of aged care and well-being

Another form of taint that is closely related to the physical aspects of aged care work and the associated physical taint – is moral taint (Ashforth & Kreiner, 1999, 2014; Valtorta et al., 2019a, 2019b). However, the case for moral taint is not as straightforward as it is for physical and social taint. Oshana argued that people experience moral taint when their "moral record has been compromised by the introduction of something that produces disfigurement of the moral personality" (2006, p.353). One's moral personality can be disfigured by performing tasks that flout social norms, or in other words, doing a job that society regards as of a dubious virtue, such as prostitution (Grandy, 2008; Simpson & Morgan, 2020). Jobs that ordinarily involve a dangerous or dirty environment, repetitive tasks and have few chances for upward mobility are also associated with moral taint (McDowell, 2018; Bolton & Houlihan, 2009; Simpson et al., 2019). In the context of the ARC sector, such work conditions expose workers to detrimental moral evaluations by society.

Extant studies have argued that moral judgment about right and wrong are both innate and shaped by culture, custom and socialisation processes (Haidt, 2001). Once a job is designated as dirty, others "declare a moral distance" fearing association with those performing the shameful activities (Goffman 1963). The tinge of moral taint that can be associated with doing aged care work is linked directly to the concept of body work; that is, using one's own body to care for another body (Twigg et al., 2011) because

performing personal cares “may violate the norms of the management of the body … in terms of touch, smell or sight…” (Twigg et al., 2011, p.172). The conceptualisations of aged care as dirt because of its association with “muck, slime and bodily fluids – foreground its materiality that relate to bodily sensations such as smell, touch and stickiness” (Simpson et al., 2011, p.197).

This is partly because several aspects of care invite physical responses that may be characterised as immoral, especially when performers feel disgusted by bodily waste to the extent of wanting to physically distance themselves from their residents (Isaksen, 1998, 2002a, 2002b; Twigg, 2006, 2000, 1997). Globally, several cultures hold a negative attitude:

> “…towards bodily exuviae and exudations. Faeces, urine, … ear wax, mucus, spittle, sweat and dandruff are all regarded as dirty and defiling… we … avoid these substances when produced by others and conceal those of our own making” (Oring, 1979, p.16).

In this respect, the sense of taste as well as the face and other body parts, such as the mouth, are central to an understanding of moral taint because people involved in dirty work generally used them to demonstrate disgust and rejection (Miller, 1997). For example, some people contort their facial features or spit and vomit when they come into contact with bodily waste that they are not comfortable with It has also been argued that disgust can emerge when a moral taint arises when one contravenes bodily norms, commonly called “purity violations” (Horberg et al., 2009; Kupfer et al., 2016; Russell & Giner-Sorolla, 2013). In this respect another morally staining aspect of the aged care job with significant well-being implications is the frequent encounters with nudity of the old residents. In popular literature, the representation of ageing bodies tends to accentuate the physical weaknesses of aged people by describing certain body parts as “degraded and ridiculous” as well as “grotesque and unsightly” and “wrinkled” bodies of the residents (Twigg, 1997, 2006) or “frail, dependent and ugly” (Asquith, 2009; Isaksen, 2002b). As a result, in their descriptions of encounters with elderly patients, some studies found that caregivers tended to focus on negative aspects such as “open mouths, unsavoury secretions, gaping throats, shrunken phalluses, withered vaginas and repulsive behinds” (Isaksen, 2002a, p.139). These physical reactions to the bodies of elderly patients raise several questions about the care workers’ psychological well-being. Previous studies have argued that touch or physical contact with the patient with the purpose of carrying out tasks such as body temperature or providing physical comfort and emotional containment is an essential

part of the caring profession with significant well-being effects for both the care provider and recipient of care (Pedrazza et al., 2015a, 2015b; Routasalo, 1999).

The moral taint of doing ARC work is therefore a stain on one's character, according to Ashforth & Kreiner, 2014. However, those who do dirty work do not only experience moral emotions of shame, guilt and regret, but as well experience pride in their work (Rivera & Tracy, 2014). It can therefore be argued that the case for ARC work as morally staining or stigmatised work might be difficult to sustain because in many ways, aged care is dirty work that largely does not go "counter to the more heroic of our moral conceptions" (Hughes, 1951, p.319).

Social taint of aged care and well-being

It is generally agreed that any work that involves regularly engaging with stigmatised people or groups, or work that is performed in subservience to others, creates social challenges for those doing it (Ashforth & Kreiner, 1999). Even though aged care work may be considered societally necessary, it:

> "... does not earn social rewards because it is unpleasant, physically disgusting, or associated with things that are symbolically unclean" (Rothman, 1987, p.228).

Despite the fact that no community can survive, let alone prosper without manual labour, a deeply entrenched prejudice against manual labour persists (Khan, 2001). However, as argued by Kahn (2009), caregiving "is everywhere perceived as low-status physical labour … intimately linked with social exclusion" (2009, p.1), partly because the tasks that characterise it are globally constructed as socially tainted (Ashforth & Kreiner 1999, Hughes 1962; Simpson & Simpson, 2018; Simpson et al., 2012). Proximity to dirt and involvement in dirty work produces stigmatising and marginalising conditions so that individuals are "'tainted" and disqualified from full social acceptance (Goffman ,1968, see also Ashforth & Kreiner, 1999; Bolton, 2005; Dahle, 2005, 2014; Dick, 2005; Hughes, 1951, 1958, 1971; Newman, 1999; Rollins, 1985; Stacey, 2005; Twigg, 2006).Those that do dirty work are therefore imbued with the taint or "courtesy stigma" that personifies the dirt (Goffman, 1963). The negative connotations of a stigma mean that the person doing dirty work is "reduced in our minds from a whole and usual person to a tainted, discounted one" (Goffman, 1963, p. 3). It can be argued that ARC work is socially dirty in so far as it "may be a symbol of degradation, something that wounds one's dignity" (Hughes, 1951, p.319, see also Treiman, 2013). As a result, the discourses of aged care and ARC work are replete with constructions of low status, low worth and low esteem (Banks, 2018; England, 2005b; MacDonald & Merrill, 2002). As argued by Douglas (1966), disgust leads those

involved in dirty work to be obsessed with cleanliness and purity. In the case of ARC work, most of those involved in it are always looking for opportunities for escape from the field.

To better appreciate the detrimental well-being impacts of the social taint of aged care as a dirty job, it must be remembered that work is not only a key aspect of life but also critical to how people express their personal identity, personal worth and self-definition (Bandura, 1995; Berkman, 2014; Cheney et al., 2008). Honneth's recognition theory argues that "for self-realisation, each subject in a society needs to see "him- or herself recognized as a member of the human community'' (1997, p. 18). This social recognition is largely impossible because dirty work is a "marker of devalued identity" (Simpson et al., 2019). In this respect, the concept of job titles as "prominent identity badges" (Ashforth & Kreiner, 1999, p. 417) provides interesting insights into the social stigmatisation associated with the ARC work.

Generally, people use their job titles to locate themselves on a hierarchy of prestige which they subsequently use to individually place themselves in social space, thereby setting the stage for their interaction with others (Avent-Holt et al., 2019; Manstead, 2018; Nasir, 2017; Treiman, 2013). Job titles communicate one's knowledge and status and therefore a source of personal individual pride (Baron & Bielby, 1986). This is problematic for the social prestige aspirations of aged care workers whose job's involvement with direct contact with the body and its wastes puts it in the class of occupations considered low in status (Clarke & Ravenswood, 2019; Hugo, 2005; Martin, 2007; Ostaszkiewicz et al., 2008; Twigg, 2000, p.390). The aged care job is basically another "low-level bottom-of-the-heap job" (Bates, 1993; Lee-Treweek, 1998; Skeggs 1997, 2004). In medical practice, concerns about social prestige plays out in some interesting ways. For example, because dirty work is a "marker of devalued identity" (Simpson et al., 2019), higher level staff, such as doctors, achieve separation from the polluting messy day-to-day tasks of bodily intimate care by allocating them to low level staff (Dick, 2005; Simpson & Simpson, 2018).

Another source of social taint that ARC workers endure is located within the discursive constructions of older people as "frail", "invisible", "vulnerable", and "passive others" (England & Folbre, 1999; Hochschild, 2012). These negative constructions are generally extended to the very people who provide personal care: the aged care workers (Gilleard & Higgs, 2011). Aged care workers are therefore misrecognised and devalued, primarily because care is physically dirty work, involving "degrading tasks that …society does not want to acknowledge" (Twigg, 2000, p.144).

Additionally, devaluation theory also explains that the more women who work in a job, the less visible, less recognised, less prestigious, less valued and the more denigrated and "unworthy of significant reward" it must be (Findlay et al. 2009, p.423; see also Clarke, 2015; Daly & Lewis, 2000; England, 2005a; Ford et al., 2007; Grimshaw & Rubery, 2007; Grimshaw et al., 2016; Hebson et al., 2015; Hussein & Manthorpe, 2005; Magnusson, 2009, 2010; Meagher, 2007, 2016; Palmer & Eveline, 2012; Ungerson, 2005; Ungerson & Yeandle, 2007a, 2007b; Szehebehely, 2005; Valentino, 2020). These axes of devaluation and marginalisation render care work as feminine work, socially and politically invisible and ultimately detrimental to the dignity of those who perform it (Hughes, 1951, 1958; Molinari, 2018). As a result, the dirty work of aged care generally invites a "visceral repugnance" (Ashforth & Kreiner, 1999, p. 415) from the public, because those who do it are stigmatised as "defective" or "deficient" (Bickmeir et al., 2015 see also Wrzesniewski & Dutton, 2001). This causes aged care workers to experience negative status perceptions because they think that others look down upon them (Moyle et al., 2003; Nair & Healey, 2006; Olwig, 2018). Therefore, the well-being challenge for such employees is stigma management which is widely understood to be a mentally exhausting task (Ashforth & Kreiner, 1999; Frable et al., 1990; Hughes, 1962).

At the same time, research has also found that the employees that perceive that their employment in dirty work is a personal choice tend to handle social stigmatisation better than those who feel strongly that dirty work was not out of their own volition (Baran et al., 2012). Notwithstanding pockets of positive experiences of age care work, studies show that most dirty workers remain ambivalent to their job as a result of contact with mostly adverse outsider worldviews (Ashforth & Kreiner 1999). The social taint of aged care body work is therefore a "blemish on one's relationships" (Ashforth & Kreiner, 2014).

Emotional taint of aged care and well-being

As previously discussed, aged care as dirty work is associated with physical, social, and moral taint (Hughes, 1962). However, the shift in the occupational landscape from the manufacturing and construction jobs to the dominance of the service sector occupation has resulted in increased research interest in how emotions impact workplace well-being (Grandey, 2000). Health care workers operate in a service delivery environment that involves the processing of emotionally intense events, such as death, dying, suffering and patient loneliness (Anderson & Gaugler, 2007; Boyle & Healy, 2003; Oliver et al., 2006; Stack, 2005; Wowchuck et al., 2007; Zust, 2006). The emotionally conflicting, complex and sometimes ambiguous dynamics of dirty work can

variously include disgust, shame, pleasure or pride (Bolton, 2005; Duffy, 2007; Perry, 1978). This “web of care, sadness, disgust, indifference, or deference” (McDowell, 2009, pp.171–172) as well as “pleasure and enjoyment” (p. 174), generates “emotive dissonance” or disharmony between what one feels inside and what is expressed physically (Hochschild, 1983). For example, employees are expected to stay calm in the face of tragedy or abuse from residents. Emotional labour is associated with negative psychosocial effects including burnout (Wharton, 1993), stress and self-alienation (Hochschild, 1983), role alienation (Ashforth & Humphrey, 1993), job tension (Abraham, 1999), and “emotional numbness” (Van Maanen & Kunda, 1989). It is against this understanding of the critical role of emotions in aged care and its impact on psychological/emotional health that criticism can be levelled against Hughes' (1962) and Ashforth & Kreiner’s (1999) tripartite classification of moral, physical and social taint. As a result, “emotional dirt”, which references work that involves experiences of problematic emotions, is proposed as the fourth taint (McMurray & Ward, 2014) that has an impact on workplace well-being. In many cases society outsources such work to others who act as buffers against emotional dirt on their behalf (McMurray & Ward, 2014). Central to this thesis is an explicit understanding that workplace well-being is more than the intersecting triumvirate of psychological/l, physical, and social functioning (Gasper, 2007; McMahan & Renken, 2011; McMahan & Estes, 2011b; Rees et al., 2010; Stratham & Chase, 2010) in that includes emotional and spiritual aspects of work. Workplace well-being is therefore a multidimensional construct that expresses work-related quality of life from the perspective of an employee’s physical, psychological, emotional, social, and spiritual experiences and functioning at work (Räsänen, 2011; Van Laar et al., 2007; Warr, 1987, 1999).

As already discussed, in this study, workplace well-being refers to the work-related physical, psychological/emotional, social and spiritual aspects of the work environment and their part in enabling or disenabling vulnerable employees in precarious jobs to physically, socially, psychologically/emotionally, and spiritually flourish and achieve their full potential for the benefit of themselves and their organisation. Kaplana & Chacko (2015) argued that when migrants enter into the host country, they bring with them a set of cultural traits and a particular socioeconomic and legal status, religion, their language, and their skin colour all of which will shape the experience they are likely to have in the new country. Several aspects of the aged care sector and the aged care job, for example, stigma associated with the low social status nature of the job, the physical, emotional, social and psychological/emotional taxing nature of the job and the multiple taints - physical, social, moral and emotional- associated with the job are

critical to an understanding of how well-being is impacted by work experiences in a migrant care worker context.

Conclusion

This Chapter has examined several theories and concepts that are widely agreed as having significant impact on workplace well-being in an aged care setting. The Chapter examined the widely used approach to the study of workplace well-being which has often relied on the triple model of physical, social and psychological well-being. The Chapter noted that this model needed to be expanded to enhance its applicability and suitability to a study of workplace well-being in a context of aged care and migrant care workers. To this end, the Chapter examined spirituality in the workplace. Although spiritual conceptualisations of the aged care job such as 'calling' or 'vocation' can be discussed under the rubric of psychological and social well-being, a case has been made for spiritual well-being to be discussed as a stand-alone factor. Additionally, the Chapter explored the concept of 'taint' and identified physical, social, and moral and emotional taints and their role in workplace well-being. The Chapter noted that most extant studies that discuss work environment factors in an aged care work context have generally shied away from discussing the 'nature of the aged care job itself' even though its characteristics are key to a better understanding of how the job influences well-being and why, for example, local born workers are not enthusiastic about joining the care sector as employees.

However, considering that these largely organisation- and individual employee-specific factors that impact well-being do not exist in a policy vacuum, in line with the critical perspective of this study, the following chapter will explore the broad context within which these factors happen. The broad policy context within which aged care organisations exist cannot remain invisible from theoretical analysis as that is more likely to lead to an uninformed position for those charged with recommending effective policies to improve practice in a context of well-being and migrant care workers' experiences. This broad context is made up of the neoliberal business policy environment and is an acknowledgement that macro, meso, and micro -level factors contribute to the precarious employment conditions of migrant workers (Zhang et al., 2021). The discussion on this broad neoliberal policy context of aged care work is designed to enhance understanding of the complexity of factors that impact workplace well-being especially in in a context of migrant care workers.

Chapter 3: The broad context of ARC and migrant participation

Introduction

The previous chapter defined workplace well-being as referring to the work-related physical, psychological/emotional, social and spiritual aspects and their part in enabling migrants in precarious employment to physically, socially, psychologically/emotionally, and spiritually flourish and achieve their full potential for the benefit of themselves and their organisation. In examining these dimensions of workplace well-being, the previous chapter noted that several extant models such as the Job Demand-Control (JDC) model (Karasek, 1979) and the job demand-control-support (JDCS) model (Johnson & Hall, 1988) provided rich insights into factors that impact workplace well-being at both an individual organisation and individual employee level. It is argued that critical theory challenges dominant ways of exploring and explaining organizational phenomenon (Scherer, 2003; 2009). To date, the dominant ways of analysing workplace well-being and workplace experiences have tended to focus mostly on individual and organisation level factors that impact workplace well-being as reflected in the extensive reliance on the models above. Notwithstanding their advantages, it can be argued that an overreliance on these models achieves to encourage a largely narrow perspective of how well-being interfaces with workplace experiences especially in a context of migrant care workers. Extant models therefore raise questions about what the most appropriate entry point of investigation is, as well as what the correct unit of theoretical analysis could be when examining workplace well-being in the context of ARC and migrant care workers. Therefore, whilst acknowledging the merits of nuance and specificity of the aged care work environment in enhancing understanding of the well-being-workplace experiences interface, this chapter puts forward the argument that macro-scale issues, for example, the broad policy context, largely beyond the control of individual managers, aged care facility owners or individual employees must be investigated to determine how it is implicated in workplace well-being in a context of migrant care workers' experiences.

This purpose of this chapter therefore is to examine the broad regulatory context of ARC which informs the workplace factors that influence wellbeing, and the migrant-specific factors that influence their wellbeing. Part of the justification for this wider theoretical contextual analysis is to facilitate the achievement of one of the aims of this study about 'contributing to practice by suggesting ways to improve migrant care workers' working conditions. For example, in Chapter One of this thesis, it was argued that migrants suffer from structural marginalisation issues beyond the confines of a specific aged care facility that they are a part of (Molinari, 2018; Hussein & Manthorpe,

2014). Therefore, improving work conditions raises questions about not only the quality of the work environment factors at each individual aged care facility, but as well, the role of the policy environment within which aged care facilities operate including the circumstances surrounding migrant participation in the aged care sector.

In line with the critical perspective of this study, this chapter therefore examines the potential well-being influences of migrant identities and. the neoliberal business policy environment within which aged care organisations provide care. The intention behind incorporating an examination of this broad context is to avoid poor conceptualisation of the well-being–work experiences nexus in a migrant care workers' context and to ensure that recommendations aimed at improving practices in the aged care sector recognise the complexity of range of work environment factors that impact workplace well-being in an aged care and migrant care workers' context.

Migrant identity and workplace well-being

As alluded to in the preceding Introduction, it is important to examine how migrant identities might be implicated in levels of workplace well-being by analysing their intersection with the broad theory of migration, especially the feminisation of both migration and care. The argument here is that the identities of migrants cannot be separated from the migrants' personal circumstances accounting for their migration from the less developed countries to the developed Western countries. This theoretical approach challenges the fixed, ahistorical conception of identities of migrants in the host country because migrants have a history which must be assessed in order to understand how it plays into how well-being interfaces with workplace experiences.

As introduced in Chapter One, using social identity theory (McAreavey, 2017; Jenkin, 2000; 2014; Goffman, 1969) 'migrant identity is a social construction that is shaped 'externally and internally' (Mead 1934[1974] p.164) by the migrant's largely poor individual pre-migration socio-economic circumstances, host country restrictive migration and visa policies, everyday encounters and experiences with the host country's labour market requirements, and workplace dynamics. All these combines to produce precariousness and a sense of lack of belongingness in the migrants' lives leading to individual behaviours and actions that are tied to workplace well-being outcomes. Therefore, migrant identity is characterised by lack of belonginess in a foreign place due to holding a temporary visa, belonging to a different race/skin colour, being foreign, perceived to be from a lower socio-economic position, and the label of economic, religious or political refugee (Benson, 2006; Gordon, 1964; Netto et al., 2018; Portes, 1999). These aspects of migrant identity play a pivotal role in migrants securing vulnerable jobs where the migrants are generally exploited (Anderson et al.,

2006; McKay et al., 2009; Valentine, 2010; Jayaweera & Anderson, 2008, p.14). Additionally, these aspects that characterise migrant identity such as the migrants' poor socio-economic backgrounds, temporary legal status, or temporary job holder position, race, and country of origin generally expose migrants to multiple forms of stigmatisation (Morosanu & Fox, 2013; Portes, 1999).

Insights from social identity theory are integral to a better understanding of the concept of migrant identity. A social identity is a person's knowledge that he or she belongs to a social category or group (Hammack, 2015; Hogg and Abrams 1988; Turner et al., 1987) or a set of meanings applied to the self in situations defining what it means to be who one is (Burke & Tully, 1977; Burke & Reitzes, 1981). The two important processes involved in social identity formation are self-categorization and social comparison (Hogg & Abrams 1988; Stets & Burke, 2000; Stryker, 2001; Burke, & Stets, 2009). Through a social comparison process, persons who are similar to the self are categorized with the self and are labelled the in-group; whilst persons who differ from the self are categorized as the out-group (Goffman, 1963, 1967, 1969; Jenkins, 2014; Lock & Heeire, 2017; Woodward, 1997). In relation to migrant workers, it is argued that they experience the problem of 'not knowing where one belongs' in a much more acute way (Krzyzanowski & Wodak.2008,p.95). It is therefore not farfetched to visualise migrants involved in self-categorisation asking themselves questions about post migration place identity, belongingness and social identity such as 'who am I?', 'who does the host country want me to be?', 'where do I belong?,' and 'where do I fit in?

The social identity theory concept of social comparison also suggests that the migrant identity is not a fixed phenomenon because, depending on context, individuals can take a preferred identity that aligns with internal expectations and external influences arising from social inter-action and social structures (Goffman, 1969; Jenkins, 2014). Identities are therefore not only internally and cognitively generated but also a product of external factors because there can be no 'self' outside of society given that 'each of us, as individuals, develops a sense of our own selfhood through engagement with other selves' (Mead, 1934, p.164). In this respect, Jenkins (2014) gave the example of how identities are externally assigned in a derogatory manner in the application of the term migrant in the UK. Jenkins (2014) noted that tabloid newspapers and many political groups generally portray an image of migrants as 'sponging' off the welfare system. McAreavey (2017) noted that these different labels cause high levels of dissatisfaction and distress among migrants.

As briefly discussed in Chapter One, the term 'migrant' is mired in controversy. For example, the pejorative sense of the term 'immigrant' or 'migrant' is usually used in

relation to “non-white, non-Western and low-skilled” workers (Castles, 2010; Leinonen, 2012; Lundström, 2014) who migrate from the poorer regions of the world to wealthier Western countries, whilst “white” migrants from the West are usually referred to as “expatriates, mobile professionals …” (Fechter & Walsh, 2010, p.1199; see also Croucher, 2012; Kunz, 2020; Leinonen, 2012; Lundström, 2014). In this respect, McAreavey (2017) analysed the ambiguity of the label ‘migrant’ and found that as a social construction, the term ‘migrant’ can conjure both positive and negative associations. Whilst on one hand it can positively be associated with ‘hard-working’, on the other hand, it can mean ‘less deserving’, ‘exploitable’, and ‘lazy’ (p.1) individuals. For example, individual migrants can assume the hard-working and ‘exploitable’ migrant identity in certain circumstances because of the benefits each migrant identity position brings (McAreavey, 2017). McAreavey (2017) concluded therefore that the external application or internal enactment of migrant identities bestows particular status that represents an asset or an obstacle to integration.

Several factors that contribute to the formation of the migrant identity must therefore be examined. One of these relates to the concept of migration, specifically the factors accounting for migration and how they are implicated in the enduring ‘out-group’ or ‘outsider’ postmigration place identity label (Damigella et al., 2010; Van Oudenhoven et al., 2006; Hayfield & Huxley, 2015; Zhang et al., 2019). There is no single theory which covers all the aspects of international migration that can help to map out the formation of migrant identities and the subsequent implications for how migrants categorise themselves or how others categorise them in the host country’s labour market (Hammar et al., 1997; Faist & Faist, 2000).

Nonetheless, a closer analysis of the theoretical treatment of migrants in extant literature reflects wide convergence on the view that pre-migration personal experiences of migrants play a critical role in the formation of migrant identities that are characterised by vulnerability and precarity or the label of ‘outer-group’ or ‘outsider’ (Lee & Fiske, 2006; Papademetriou & Terrazas, 2009). This is because it is at the pre-migration and migration stages that migrants start to develop particular patterns of intergroup cognitions, attitudes and behaviours as well as anticipate and prepare for future post-migration intergroup interactions (Tartakovsky, 2007; Yijälä & Jasinskaja-Lahti, 2010). “The migrant is often described as the emblem of the precariat – the precarious figure per se (Jørgensen, 2015, p.3.) In this respect, the role of pre-migration experiences in generating this ‘migrant precariat’ (Schierup et al., 2006; 2014; 2015) Schierup et al. 2015) identity in the host country is captured in Figure 3.1, specifically in the ‘pre-migration phase’ quadrant:

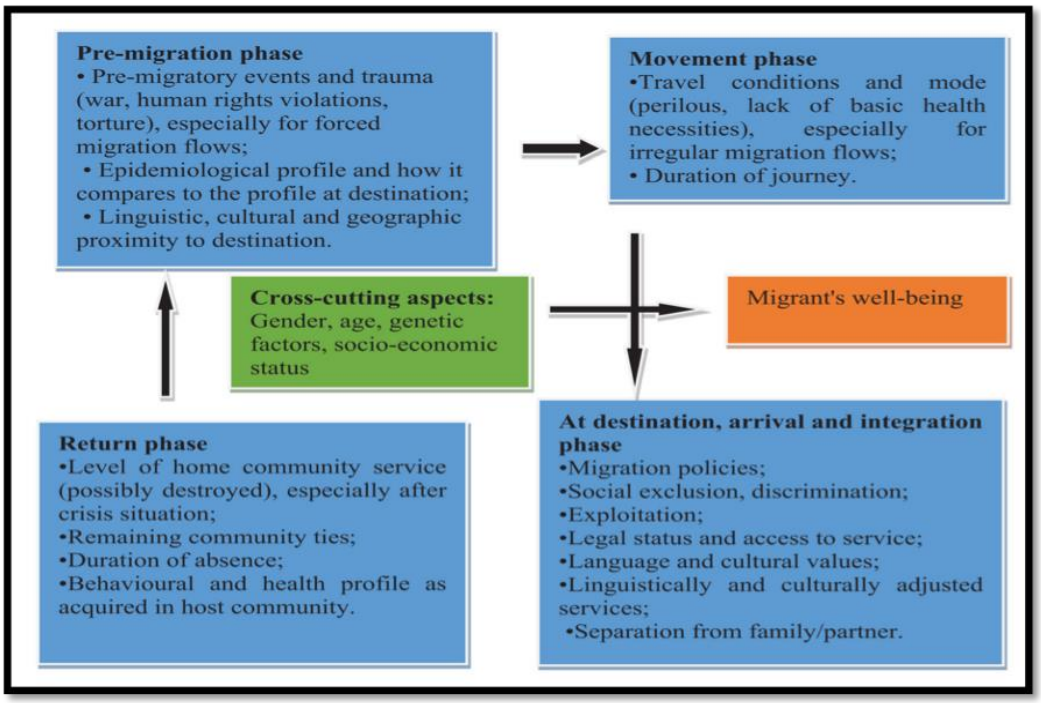

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Figure 3.2 Social determinants of migrant health at stages of the migration process
Source: Kanengoni et al., 2018, p.6.

Figure 3.1 shows that migrants that move from the developing countries to the Western countries are already experiencing significant challenges even before they arrive in the host country. These challenges significantly shape who they are in the host country. This also resonates with Castelli's (2011) account of the drivers of migration, as captured in Figure 3.2 Drivers of migration.

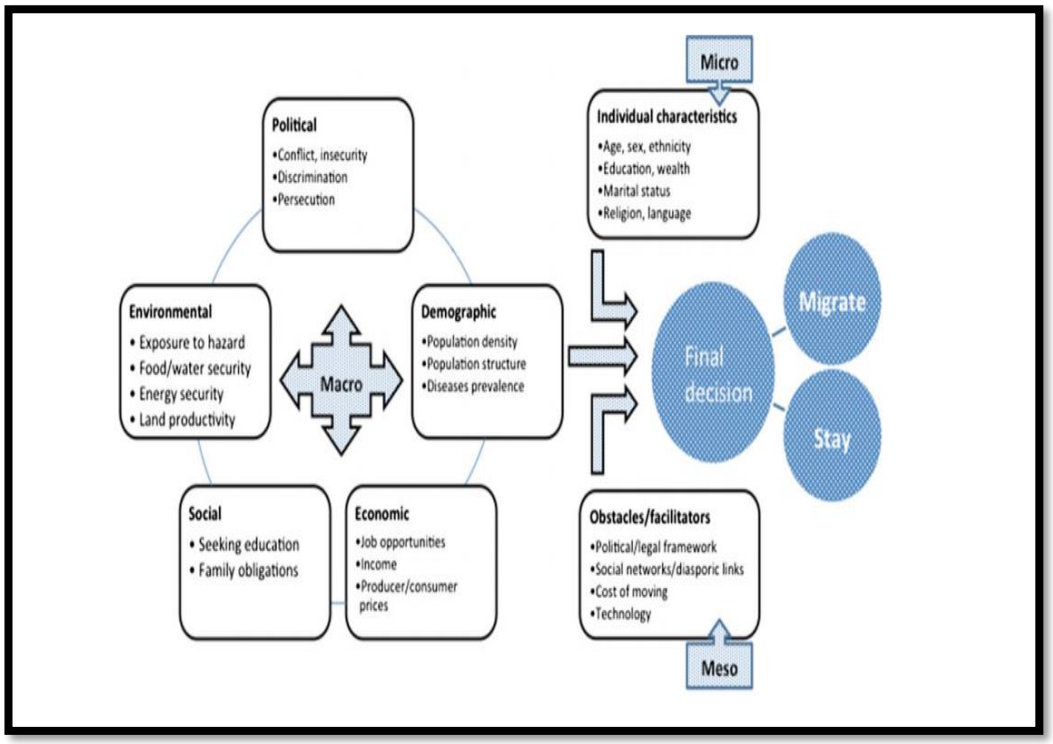


Figure 3.3 Drivers of migration
Source: Castelli, 2011, p.3

A variety of push, pull and network factors interact to create a highly volatile and mobile global community (Richmond, 1994; Baum, 2012). In this respect, it is widely agreed that in most developing countries, migration is not necessarily voluntary but a result of many factors like civil conflicts, restraining state policies and a desire to escape poverty, backwardness, and poor socio-economic and constrained life opportunities (Piore, 1979; Portes & Böröcz, 1989; UNESCAP, 2007; Hagen-Zanker, 2008; Shrestha, 2017; Castelli, 2018; Van Hear et al., 2018; Segal, 2019). Except for these negative circumstances, ordinarily, most people would prefer to stay in their country of origin (Walsh & O'Shea, 2009). As a result, the motivation to escape constrained home socio-economic opportunities through migration has become a significant influencer of micro-level individual career choices with many people in developing economies, for example, choosing health careers because they offer migration prospects (Beine et al., 2001; Nystrom & McArthur, 1989; Carr et al., 2005; Ali, 2007; Connell et al., 2007; Mkondo et al., 2007; Edwards & Quinter, 2011; Boadi-Kusi et al., 2015). However, some studies have noted that while in appearance, migration arises out of a series of 'rational' economic decisions by individuals to escape their immediate situation, in reality its fundamental origin lies in the history of past economic and political contact and power asymmetries between sending and receiving nations (Portes & Böröcz, 1989).

Castle's (2000) classification of migrants provides insights not only into circumstances accounting for the formation of precarious migrant identities, but also hints at the sources of the vulnerabilities that characterise migrant lives in the host country as well as the reasons why migrants are overrepresented in poorly paid jobs such as in aged care.

Table 3.2 Classification of migrants
Source: Adapted from Castle (2000)

Migrant Category	Their characteristics
Temporary labour migrants	These are men and women who migrate for a limited period (from a few months to several years) in order to take up employment and send money home.
Highly skilled and business migrants	People with qualifications such as managers, executives, professionals, technicians or similar, who move within the internal labour markets of transnational corporations and international organisations, or who seek employment through international labour markets for scarce skills.
Family members reuniting	Migration to join people who have already entered an immigration country under one of the above categories.
Irregular migrants	Also known as "undocumented" or "illegal migrants".
Refugees	A person residing outside his or her country of nationality and unable or unwilling to return because of a "well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion" (United Nations 151 Convention relating to the Status of Refugees).
Asylum-seekers	People who move across borders in search of protection, but who may not fulfil the strict criteria laid down by the 1951 Convention.
Forced migration	In a broader sense, this includes not only refugees and asylum seekers but also people forced to move by environmental catastrophes or development projects (such as new factories, roads or dams.

Castle's (2000) classification of migrants makes it clear that, except for the "highly skilled and business migrants' category", the rest of the migrant categories comprise people who are pushed out of their home countries because of poor socio-economic, political and religious conditions.

The literature therefore generally supports the view that most migrants are pushed out of their home country by poor socio-economic, social and other circumstances (Piore

1979; Castles, 2000; Parkins, 2010; Walton-Roberts, 2015; Van Hear et al., 2018; Segal, 2019). It is in this context that migrants 'identities have attracted labels such as 'target earners' (Piore,1979) primarily because, in Piore's view, the migrants' goals are to return home after accumulating enough resources to support a better life in their country of origin. These largely constrained pre-migration circumstances therefore construct migrants as vulnerable and precarious members of society who are more likely to be engaged in precarious "3-D jobs – dirty, dangerous, physically demanding", and sometimes insecure, degrading work at the lowest end of the labour market beneath the dignity of the average non-migrant worker (Fitzgerald, 2007; Fullin & Reyneri, 2011; Holgate, 2005; ILO, 2014; ILO, 2015a, 2015b, 2016b; Lewis et al., 2014, 2015; Martin, 2007; McGregor, 2007; Preibisch & Otero, 2014).

Existing literature on migrant employment points to the role of interconnected factors at the individual, familial, community and wider policy levels, often operating transnationally, that shape the precarious labour market position of migrants in the host country (Hamilton et al., 2021; Shutes, 2012; Robertson, 2014). Other studies have also examined extensive constraints that are experienced by migrants, particularly those associated with gendered and racialised norms in labour market and family contexts and how these constraints leave migrants with little agency in the labour market (Chun & Cranford, 2018; Evans, 2017). The concept of bounded agency recognises that 'agency is a socially situated process, shaped by the experiences of the past, the chances present in the current moment and the perceptions of possible futures' (Evans, 2002, p.262). In this respect, Chun, & Cranford (2018) examined how the intersectional dynamics of gender, migration, and labour shape the trajectories of especially immigrant women into aged care work. In the same vein, using the concept of bounded agency, Hamilton et al., (2019) argued that migrants operate within constrained employment opportunities in the host country, effectively impacting on their career pathways.

Current literature therefore identifies intersections between various constraints tied to the migrant identity that shape their entry into low level jobs such as aged care. For women, these intersections include the constraints of being a migrant and the constraints of being a parent (Corby & Stanworth, 2009).Other studies identity how factors such as the lack of recognition of skills, poor language proficiency (Reyneri 2004; Wessendorf, 2018), discrimination (Creese & Wiebe, 2012) and lack of social networks (Gilmartin & Migge 2015; Wessendorf, 2018) and their intersections with gender norms and family responsibilities (Doyle & Timonen 2010; Santero & Naldini 2020) ultimately succeed in producing considerable constraints on migrant employment

opportunities. These constraints are therefore responsible for migrants ending up in frontline aged care and other low status jobs (Hamilton et al., 2021).

Other studies have argued that migrants 'satisfice' or choose work that is 'good enough but not optimal' (Corby & Stanworth, 2009), leading many into low paid highly feminised sectors such as care (Doyle & Timonen, 2010; Shutes, 2012; Schwiter et al., 2017). It can also be argued that migrants take up any low level low-paying jobs that becomes available such as in the aged care sector (Agadjanian et al., 2017; ILO, 2018, 2011; García, 2017) to avoid unemployment because unemployment has strong ties with poor mental, social and physical well-being (Blustein et al., 2016; Clark & Georgellis, 2013; Clark et al., 2008; Dockery, 2006; Flatau, et al., 2000; Winkelmann & Winkelmann stress, 1998). Additionally, migrants must not only find a way to support their economic livelihood in the host country but may have to remit earnings back to their home country to address the care gap they created through emigration (Hochschild, 200a; 2000b; Yeates, 2009; Lutz, 2018).

Several other reasons that account for why migrants fail to secure jobs that are commensurate with their previous qualifications and work experience include, for example, lack of local qualifications, local working experience and acceptable soft skills or employability skills (Bardy et al., 2017; Borjas, 1985; Chiswick, et al., 2003; Esses & Dietz, 2007; Iqbal, 2017; Mpofu & Hocking, 2013; Newson, 2013; Siar, 2013). Other studies have however, argued that the 'soft skills' argument that the employers use to rationalise their recruitment of migrant workers can be a smokescreen for a desire to recruit workers over whom they can exert control (Ruhs & Anderson, 2010). In this respect, Moriarty et al., (2012) found that many employers prefer migrants because they possess superior 'soft skills or interpersonal competencies, such as the ability to communicate or to work constructively with colleagues. Several studies therefore blame the host country's "immigration and integration policies", "professional accreditation systems," and "discriminatory labour market practices" that operate along racialised and gendered lines for pushing highly educated immigrants into either unemployment or under-unemployment (Creese & Wiebe, 2009; Teelucksingh & Galabuzi, 2007).

Notwithstanding these contrasting perspectives of the employment challenges that are experienced by migrants, it can still nonetheless be argued that 'possession of foreign qualifications,' 'lack of local qualifications', 'lack of local working experience', and 'lack of acceptable soft skills or employability skills' make migrants less competitive in the labour market worsening their vulnerable and precarious social and economic positions in the host country. Therefore, the 'lack' metaphor succinctly captures the plight and

precarious identity of migrants in the host country by emphasising that migrants belong to an outer group that 'lacks' what is essential for survival within a given context. This migrant state of 'lack' and its attendant vulnerabilities and precarities are integral to how migrants respond to conditions of work that impact on their well-being. Research has found that workers in precarious employment frequently experience vulnerability (Standing, 2011). Vulnerability is a contested term linked to conditions of work (Hewison, 2016; Kalleberg et al., 2000) or the workers themselves (Burgess et al., 2013). In this regard, the state shares most of the blame for their role in producing circumstances that result in migrants being described as precarious workers doing precarious work (Dyer et al., 2011; Alberti et al., 2013; Campbell & Price, 2016; Fudge, 2021).

Visa conditions and the migrant identity

The discussion on migrant identity, especially precarious migrant identity, shows that its creation and subsequent implications for workplace well-being are mediated by institutional contexts beyond events happening within the confines of a specific aged care organisation. Extant studies have argued that migrants are especially vulnerable to conditions of precarity (Buckley 2014; Basok et al. 2015; Paret & Gleeson 2016; Buckley et al., 2017; Platt et al., 2017; Strauss, 2017; Strauss & McGrath, 2017). It is also argued that precarity is not only created by workplace dynamics, but also by immigration regimes or 'the ongoing interplay of neo-liberal labour markets and highly restrictive immigration regimes' (Lewis et al., 2015). As briefly mentioned previously, one of the enduring labels of migrants is the 'precariat' (Standing, 2011) \and 'outsider' (Elias & Scotson, 1994; Sniderman et al.,2002; Lee & Fiske, 2005) or 'outergroup' (Ekman, 2019). The formation of the precarious migrant identity label in relation to the role of the immigration controls, specifically the migrant visa, can be enhanced by making reference to the concept s of 'place' and 'social space' (Tuan,1979). Previous studies have observed that temporary workers embody specific relationships with and use of space (Collins, 2012). Space derives from, but is not identical to, place (Baynham, 2003). This means that the host country by virtue of its name, for example, New Zealand, is a place, defined by both its geographic location and its name. For migrants, however, New Zealand is not just a geographic place but a "practiced" place and therefore a 'social space' (Baynham, 2003; de Certeau, 1988; Tuan,1979) that is a product of the practices associated with, for example, labour market practices and relationships between migrants and locals including state policies governing their participation in different facets of the host country's socio-economic, religious and political space.

It is in this context of the meaning of social space as ‘practiced place’ that the role of the state in producing precarious migrant identities through the practices of immigration controls and visa entry conditions is examined. Globally, state migration policies have resulted in increasing numbers of transnational workers with ‘various noncitizen statuses and uncertain temporal horizons’ (Robertson, 2016, p.2263). In this respect, Collins & Bayliss observed that;

> “Temporary migration schemes that prioritise labour market flexibility, skills assessment and a reduced social burden, insert both legal and social stratification into the workplace and community through the restricted rights and future pathways available to migrants” (2020, p.1).

The migrant visa conditions mean that migrants cannot afford to be unemployed, especially since being employed is their licence to staying in the host country (Fudge, 2012). This is supported by Anderson, cited in Fudge (2021) who argued that;

> “[T]hrough the creation of categories of entrant, the imposition of employment relations and the construction of institutionalized uncertainty, immigration controls work to form types of labour with particular relations to employers and to labour markets. They combine with less formalized migratory processes to help produce "precarious workers" that cluster in particular jobs and segments of the labour market” (p.96).

It is therefore not surprising that the host countries’ tied visa system or bonded employer contracts that allow migrants to enter a country but only to work for one specific employer or in one specific location is blamed and criticised for creating spaces of structural vulnerability for migrant workers (Carter et al., 1996; Piper 2004; Bauder, 2006; Ruhs & Anderson, 2006; Fudge, 2012). Holding a temporary visa permit or work visa ultimately differentiates migrant workers from non-migrants because the visa confers or withholds certain legal, labour, political and economic rights (García, 2017). Referred to as “un-citizens” (Nash 2009), migrants grapple with “temporariness” which starts with the terms of entry into the host country, stipulating the length of stay, kinds of work that can be taken, as well as the ability to change jobs (Koleth, 2017; Piper & Withers, 2018). In this regard, Yeoh’s (2005) Singapore based study found that work permit holders enjoyed few privileges and faced restrictions that curtailed their access to the local labour market. To make matters worse, many of the workers on such visas are generally relatively poor, with family dependents back in their home countries relying on their wages for school, healthcare or other necessities (LeBaron et al., 2016). Additionally, many of these workers will also have indebted themselves heavily

to fund their travel and the purchase of their visa (OSCE, 2009). They thus face very high opportunity costs if they attempt to leave their employment, even when that has become abusive or exploitative (LeBaron et al., 2016). It has also been established that unscrupulous employers capitalise on these vulnerabilities and use threats of denunciation to both bolster migrant workers' productivity and to prevent them from organising (Lenard & Straehle, 2010; Wright & Clibborn, 2017).

The formation of the 'precariat' migrant identity is also given impetus by the visa conditions which establish conditions of stay in the host country's social space. In this respect, one of the pressing issues with regard to its role in producing vulnerabilities in the migrants' lives, is the salary stipulation that determines whether a migrant's application for permanent residency is going to be considered or not (Walsh & O'Shea, 2010). In most cases, the stipulated figures are way above what migrants in a low-level occupation such as caregiving can earn. In this respect, it can also be argued that the Western nations' credentialing policy is a double-edged sword (Guo, 2009). Whilst on one hand, the intent of credentialing is to ensure quality of care, it can also be construed by qualified migrants as discriminatory and a barrier to entry into the job that they are already qualified to do. As a result, even though migrants are employed in several skilled occupations, they are generally more likely to be in insecure temporary roles not commensurate with their previous education, work experience and/or skillset (Bauder, 2006a; Kosny et al., 2016; MacKenzie & Forde, 2007; Reid, 2012; Ryan, 2007; Ronda-Perez et al., 2012). As a result, most migrant workers tend to take greater job risks whilst remaining silent about OHS issues (ILO, 2014; Moyce & Schenker, 2018; Preibisch & Otero, 2014, 2013; Takala et al., 2014) resulting in them reporting poorer health than their local-born colleagues (Sousa et al., 2010).

From a well-being perspective, it is argued that:

> "…temporariness as a label has pernicious social consequences, categorising large groups … as less attached to a locality due to the 'termed' conditions of their stay" (Chacko & Price, 2020, p.2; see also Anderson, 2010).

Ultimately, the status of being a temporary resident in a foreign country holding a temporary visa confers the migrant care workers with a negative identity of temporariness or transience, and therefore, not belonging to that place.

Another defining aspect of the migrant identity is race. It is argued that migrants pay an "ethnic penalty" which exacerbates their vulnerability as workers (Heath & McMahon, 1995). As succinctly put by Carter et al., (1996) "the racialised nature of immigration regulation both structures the way in which migrants are situated within the labour

market and valorises notions of 'race' difference" (p.135). In this respect, it can be argued that underemployment of migrants in the host country is reflective of structural marginalisation. Therefore, the precariousness of the low-level jobs, for example, aged care, that migrants are in most cases involuntarily drawn into is "intensified by the existential precariousness of their lives as migrants and as racialised workers" (Sahraoui, 2019, p.viii). The foreigners' migrant identities are defined by race with far reaching implications for their social and economic security in the host country (Keskinen, & Andreassen, 2017; Runfors, 2016; Trimikliniotis, 2018). Globally, there is ample evidence that racialised care workers experience different forms of discrimination and racial prejudice or racial stereotypes in the workplace (Anderson, 2012; Agudelo-Suárez et al., 2009; Anderson & Shutes, 2014; Cangiano et al., 2009; Doyle & Timonen, 2009; Hussein et al., 2014; ILO, 2011; Steven, Hussein & Manthorpe, 2010; Stevens et al., 2011; Walsh & O'Shea, 2009; Williams & Gavanas, 2008).

It has also been observed that racialised stereotypes operate differently as hierarchies in different countries (Anderson, 2012; Atanackovic & Bourgeault, 2013; Lowell et al., 2010; Timonen & Doyle, 2010a, 2010b; Walsh & O'Shea, 2009, 2010). For example, Williams & Gavanas (2008) found that some UK employers consider Latin American care workers "more loving" and Eastern Europeans "more hard working", while Australians are considered "cheerful and flexible". In Europe, women from the Philippines are often most preferred as carers, whilst in France, black African workers are considered "dirty" (Narula, 1999a, 1999b). Instances of ethnic minorities being discriminated against in ARC by managers/supervisors, patients, family relations of patients, and co-workers are well documented (Banerjee, 2008; Cangiano et al., 2009; Hurtado et al., 2012; Stevens, Hussein & Manthorpe, 2012; Likupe, 2015; Nichols et al., 2015; Sahraoui, 2015; Walsh & O'Shea, 2009; Walton & Rogers, 2017). Some of the discriminatory practices often take the form of unfair workload allocation, denial of organisational support and unfair complaints processing (Spencer et al., 2010). The managers of those in stigmatised occupations that unfairly allocate workloads between migrants and local-born employees can be accused of "normalizing the taint" (Shantz & Booth, 2014, p.1458) associated with aged care.

From a well-being perspective, it is argued that discrimination is a critical stressor that over time diminishes individual employees' psychological and physiological resources (Ganster & Rosen, 2013; Williams & Mohammed, 2009). Koskela's (2014) Finland based study found that non-Western highly skilled migrants were less accepted and their categorization as culturally different, burdened their interaction with the dominant

society. This is echoed by several studies which found that skilled migrants are not always readily accepted and absorbed into the labour market (Fernando et al., 2016; Rajendran et al., 2017) and therefore experience vulnerability, anxiety, fear and helplessness in the host country (Lu et al., 2011; Safi, 2010).

It is therefore not surprising that compared to local born employees, migrant workers are commonly identified as an at-risk disadvantaged group that is vulnerable to unfair employment practices and at high risk of poor well-being (Brooks, 2007; Eurofound, 2010; ILO, 2011, 2013, 2014, 2015c, 2016a, 2017; Lee et al., 2012; Qureshi et al., 2013; Siegrist et al., 2012; Sterud et al., 2018; Mahon & Michel, 2017; Shutes & Chiatti, 2012).

Finally, another dimension of the migrant identity is captured in the notion of 'lack of a sense of belongingness'. The status of being a foreigner and living far away from one's home country has serious ramifications on the lives of migrants. Mattes et al., (2019) have observed that migrants tend to feel isolated and in perpetual search for a sense of belongingness. The migrant is an embodiment of "borderless belonging: fluid, transitory, and un-rooted" (Mattes et al., 2019, p.302) and therefore vulnerable to stressors materialising from enduring long periods away from their families and friends, starting a new job and resettling in a foreign country (Chiswick et al., 2008; Bahn, 2013, 2015). As argued by Safi (2009) "migration and establishment in a new country go together with sorrow, melancholy, and despair" (p. 160), (see also Chiswick et al., 2003; Colic-Peisker & Tilbury, 2006; Syed & Murray, 2009; Teelucksingh & Galabuzi, 2007). This is partly because the new social contexts that the migrants operate in are characterised by limited social networks resulting in the migrants struggling to develop and maintain social relationships (Bretones, 2020).

Studies have established that social connectedness is an important well-being determining factor because it impacts on one's mental health (Caxaj & Gill, 2016; Mahar et al., 2014; Mendoza et al., 2017). As a result, one of the most critical factors that impacts workplace well-being is social relationships in the form of "social integration", "social networks", "social ties" or "social support" (Berkman, et al., 2000; Erdil & Ertosun, 2011; Rautenbach, 2015). In this respect, some scholars have underscored the importance of networks as avenues for information and sharing of values and making cultural connections (Massey, 1990; Portes & Sensenbrenner, 1993). Migrants' identities are therefore generally characterised by a lack of social integration, social networks, and social ties in the host country with far reaching consequences for their social, psychological and emotional well-being. The implications of this identity of migrants for workplace well-being must therefore be considered from

the perspective of the human innate desire for stability, social inclusion and acceptance (Basok & George, 2020; Caxaj & Gill, 2016; Mahar et al., 2014; Mellor et al., 2008).

When all the preceding issues are considered together, it is easy to see how they are implicated in the status of a migrant as a vulnerable temporary outsider who does not belong in the host country because of race and lack of various employability skill-sets required to be competitive in the host country's labour market (Borjas, 1985; Chiswick, et al., 2003; Esses & Dietz, 2007; Mpofu & Hocking, 2013; Siar, 2013). It can therefore be concluded that this interplay of these complex factors that produce migrant identities, leads migrants to not only self- categorise, but to be categorised by the host country as 'outsiders' or members of the 'outer group' with limited rights in the new host country's social space. As argued by McAreavey (2017), the creation of a migrant identity limits the structures and networks from which migrants may draw resources and in so doing curtails the possibilities for social change due to migration.

Feminisation of migration and care, and migrant precarious lives

The preceding paragraphs have established that migrant workers' personal backgrounds are characterised by significant challenges that shape their migrant identities which ultimately produce significant vulnerabilities in their life and work experiences. Additionally, it was argued that there is a complex interplay of factors that contribute to the formation of migrant identities, specifically the vulnerabilities and precariousness that characterise them. To that end, the state's role in producing precarious-migrant identities was identified in relation to the state's visa policies and bonded employment contracts. However, the conditions that produce precarities associated with migrant identities extend beyond these discussed factors and include the migration phenomenon, which is intertwined with concept of feminisation of care and the neoliberal policy environment within which the aged care facilities provide care.

Caregiving remains women's work far more than men's (Gerstel, 2000) and men who do care work are therefore generally considered to be doing something "unusual" in terms of gender roles (Comas-d'Argemir & Soronellas,2019). As a result, this gendered view of care work has been shown to be a source of both fulfilment and burden for care workers (Esplen, 2009). Boucher (2007) has observed that the gendered way in which skill is ascribed and formalised within the Australian and New Zealand Standard Classification of Occupations (ANZSCO) framework has meant that care is constructed as 'low skilled' within the two countries' migration settings and consequently frontline care workers have not normally been able to qualify for either permanent or temporary skilled migration.

The care worker role which is socially prescribed for women in many patriarchal societies has resulted in the undermining of their rights and limiting of opportunities and choices with significant negative well-being impacts (Billing, 2011; Chopra, 2014; Nentwich & Kelan, 2014). This perception of aged care work as unskilled work is a gendered view based on traditional skill assessments that value mechanical and technical skills associated with masculine work more highly than 'soft skills' associated with caring, which are seen as an innate attribute associated with women (Ravenswood & Harris, 2016) see also Bourgeault & Khokher, 2006; Neysmith & Aronson, 1996). It has been observed that the description of aged care work from the viewpoint 'love of the job' manages to obscure the importance of high-level soft skills such as relationship building, observation, judgement involved in caring (Neysmith & Aronson, 1996; Cohen, 2015). As a result, such caregiving skills are rarely acknowledged or recognized (Ravenswood, 2011) and this ultimately establishes the work as low skilled and low status, which legitimates the low pay, low regard of aged care work (Carrasco et al., 2011; Charlesworth & Heap,2020 Ravenswood, 2011; Ravenswood & Harris, 2016).

It is in this context of gendered nature of aged care work that the role of migration in the feminisation of care is examined here. The contribution of feminisation of international migration as well as the gendered division of labour to the creation of vulnerabilities and precarities dominating especially female migrants in foreign labour markets (Gheau, 2012) deserve critical analysis in so far as this can enhance understanding of workplace well-being in a context of ARC and migrant care workers. It is argued that to understand the feminisation of migration "we need to appreciate influences operating at the global, state, community, and household levels" (Hofmann & Buckley, 2013, p. 510). To this end, in examining global migration trends, it is evident that gender relations in both sending and host societies have played critical roles in shaping gendered patterns of migration (Tittensor & Mansouri, 2017). Although one cannot claim a uniform feminisation that speaks of women as the dominant migrant category, there is ample evidence showing that due to a variety of gendered systems of inequality in different home country labour markets and cultures, more women than men tend to migrate to Western countries (Cooke & Bartram, 2015; Heering et al., 2004; King-Dejardin, 2019; Marchetti, 2018; Morokvasic, 1984, 2003; Nawyn, 2010; Read, 2004; UNDESA, 2013; Williams, 2011). Therefore, while migrant women are employed in a variety of sectors, they "predominate in care work" (Mahon, 2020, p.54). Although, characterised in this way, migration can be considered a powerful socio-economically emancipating experience for women because it provides them with self-empowerment opportunities (Bach, 2003; Barrett & Duffy, 2007; Pillinger, 2007), it is

also widely agreed that the women who migrate may be subject to multiple discrimination due to the intersections between their race, precarious migrant agency as females and as precarious workers (Chacko & Price, 2020; Moyce & Schenker, 2018).

The concept of “global care chain” which refer to “a series of personal links between people across the globe based on the paid or unpaid work of caring” (Hochschild’s (2000a, p.131) provides some perspective of the challenges experienced by migrant women who provide care elsewhere, leaving behind their own families with limited care. Practicing “transnational motherhood” (Hondagneu-Sotelo & Avila, 1997) negatively affects the psychological and emotional well-being of these mothers who are ordinarily expected by society to take care of the children (Dreby, 2009; Menjivar & Abrego, 2009; Lutz & Palenga-Möllenbeck, 2012; Parrenas, 2001, 2005; Read, 2004). In the host country, the pressure does not let up for these migrant women as they are “harshly reminded of their social citizenship obligations by their countries of origin” (Lutz & Palenga-Mollenbeck, 2012, p.2). Female migrants therefore find themselves in a dilemma as they need to balance their obligations as “citizen-the wage-earner” against those of “citizen-the carer” (Lister, 2003, p.176). This is echoed by Robinson (2017) who argues that

> “[F]eminised caring work, or love labour, poses a well-known dilemma for women’s citizenship. It defines certain women as essential to the nation as reproducers and carers and yet on the margins of full citizenship” (p.60).

Additionally, female migrants endure the challenges of temporarily or permanently taking up unskilled jobs that are also generally socially devalued, such as aged care, in a process known as deskilling or downgrading (Dustmann et al., 2013; Wojczewski et al., 2015). It must also be noted that the employment of migrant women in the host country is generally connected to their characteristic of being vulnerable to exploitation by employers (Shutes & Chiatti, 2012; Tyner, 2003). Women migrants are therefore more marginalised in the labour market owing to their “multiple vulnerability” as migrant women doing a highly feminised and undervalued aged care job (ILO, 2015a, 2015b, 2014, 2011; Morokvasic, 1984, 2003). This is additional to working in racialised environments where they endure racial discrimination and other racially motivated forms of treatment (Banerjee, 2008; Esses & Dietz, 2007; Krings et al., 2014). This discussion indicates that workplace well-being in a context of migrants is intertwined with feminisation of both migration and aged care jobs (De Leon Siantz, 2013).

Men's experiences with women's work and well-being

The preceding discussion about the challenges experienced by female migrant workers in the labour market of the host country should not be taken to mean that the migrant men – who are also increasingly joining ARC – are immune to work-related challenges. Concepts of femininity and masculinity provides insights into identity challenges experienced by men who become care workers after migration. On the one hand, due to the social construction of masculinity and femininity, the men that join female-dominated occupations tend to experience better work opportunities than the females. For example, masculinity is "often associated with competence and mastery, in contrast to femininity, which is often associated with instrumental incompetence" (Williams, 1995a, pp.106-107; also see Sczesny et al., 2006; Williams, 1995b). Masculinity therefore confers one with a "higher status … more power and greater privileges than women or less masculine men" (Berdahl et al., 2018, p.425; see also Ridgeway & Correll, 2004). Since men are perceived to be more skilled in the physical abilities of strength, or exercise of power, it is generally assumed that they are more capable of generating authority (Aguilar-Cunill, 2017). As a result, they are often appointed to the most prestigious and materially rewarding positions when they take up jobs in traditionally female occupations (Aguilar-Cunill, 2017). Such men therefore regain their traditional positions of authority and control or "respectable domestic masculinity" (Calasanti & King, 2007; Cox, 2012; Gallo & Scrinzi, 2016; Gallo et al., 2016; Wingfield, 2009) in the workplace. The reproduction of gender hierarchy and inequality in the workplace is therefore unavoidable when men join female-dominated jobs (Agadjanian, 2002; McDowell, 2015). It is therefore argued that gender is a "constitutive element of immigration because it permeates a variety of practices, identities, and institutions implicated in immigration" (Hondagneu-Sotelo, 2003, p.9). As a result, the male migrant caregivers, especially from oppressive masculine dominant cultures, have been criticised for "colonising feminine labour space" (Pullen & Simpson, 2009) and reproducing the same untenable patriarchal attitudes and labour market conditions that some female migrants ironically escaped from through immigration.

On the other hand, although the men that work in "women's professions experience a glass escalator effect" that enables their faster progression and "upward mobility" (Wingfield, 2009, p.5), their sense of masculinity sometimes pays a heavy penalty (Lupton, 2000). Due to the gendered societal categorisation of jobs (Holmes, 2006), men who have grown used to holding more prestigious, better-paid jobs, find it awkward and demeaning to work in low-status female-dominated jobs (Lupton, 2000). In this respect, Sobiraj et al. (2015) found evidence of more pronounced social stressors for masculine men in female-dominated occupations than for men in

occupations with a higher preponderance of men. It has been observed that generally society treats men who do “women’s work” as deviants for failing to uphold the ideals of “hegemonic masculinity” (Buschmeyer & Lengersdorf, 2016, p.1; see also Baxter, 2010; Isaksen, 2002a; Ku, 2011; Nentwich & Kelan, 2014; Mcdowell, 2015, 2018). Such men are “marked” and ridiculed as “weak” and unsuitable for “real men’s work” (Buschmeyer & Lengersdorf, 2016; Nentwich & Kelan, 2014). Taking up women’s work is therefore not entirely a positive experience for the males because they often become objects of negative feminine stereotypes (Forsman & Barth, 2017). Other studies have also criticised the glass escalator concept for failing to account for racial dynamics and migration in suggesting that men that join female-dominated occupations quickly experience upward mobility (Hussein & Christensen, 2017; Wingfield, 2009). There is also a price associated with hegemonic masculinity, because “…men come to suppress a range of emotions, needs, and possibilities, such as nurturing, receptivity, empathy, and compassion, which are experienced as inconsistent with the power of manhood” (Kaufman, 1994, p.148).

Ultimately, a closer analysis of both male and female migrants can easily lead to the conclusion that they both experience significant challenges that affect the core of their identity and their lives in the host country. In this respect, the following discussion situates issues about migration, feminisation of both migration and care, and migrant identities within a broad policy context of neoliberalism. This is because organisations don’t exist in a policy vacuum. Additionally, it is argued that work conditions encompass various macro and micro “ecological, material, technical, economic, social, political, and legal”, and organisational circumstances and characteristics within which labour activity and relationships are developed (Ochoa & Blanch, 2019, p.7). This clearly suggests that, for example, the low wages that are paid to care workers by specific individual aged care facilities might not be wholly attributed to the individual workplace practices but also to other factors that individual care organisations have no control over. This point is further clarified in the discussions surrounding the concept of relational care and its importance to the well-being of those who receive and provide care. Banerjee & Rewegan (2016) therefore concur with Martin et al.’s (2015) view, that the nature of relational care and any relationship that develops within ARC facilities that impact well-being of both care providers and care recipients are shaped by the broader socio-cultural, political economic, organisational and policy contexts (Banerjee & Rewegan, 2016; Sims-Gould et al. 2010; Ward-Griffin et al., 2012).

Neoliberal context of aged care delivery and migrant participation

The previous chapter defined workplace well-being as referring to the work-related physical, psychological/emotional, social and spiritual aspects and their part in enabling employees to physically, socially, psychologically/emotionally, and spiritually flourish and achieve their full potential for the benefit of themselves and their organisation. As indicated in the Introduction of this Chapter, to adequately address one of the objectives of this thesis - contributing to practice by suggesting ways to improve migrant care workers' working conditions and improving aged care employment practices - it is important to understand the complexity of the raft of factors that either enable or disable migrant care workers to physically, socially, psychologically/emotionally, and spiritually flourish and achieve their full potential for the benefit of themselves and their organisations. It is argued that 'a familialistic care regime induces a 'migrant in the family' model of care, while a liberal care regime leads to a 'migrant in the market' model of employment…' (VanHooren, 2012, p.133). To this end, it was argued in the previous chapter that a significant concern with current approaches to the well-being and work-experiences interface is that current models do not appreciate the role of the broad policy environment in shaping the nature of that interface.

Current models seem to suggest that an organisation and its workplace practices including the employees are the boundaries that circumscribe the primary locus of workplace well-being. By placing a lot of emphasis on the impact of organisation-controllable work environment factors on well-being, the extant well-being models inadvertently promote an individual employee and organisation-insular approach to the study of workplace well-being. Such an approach is likely to restrict the characterisation and formulation of issues impacting workplace well-being to individual failures or weaknesses of aged care organisations even though the problems may be structural or may have a far broader policy dimension beyond the confines of both the individual aged care organisations and employees. Therefore, this examination of the broad public policy context is an affirmation that aged care organisations, managers and employees exist in a complex economic, political and social business environment that in turn reflects complex ideological beliefs about how society or work should be structured (Freeden, 2001; Harvey, 2005; Knight, 2006; Selberg, 2013; Ward & England, 2007).

A study of well-being and work experiences would therefore be incomplete without engaging with the business policy environment and its implications for migration in so far as it creates and perpetuates migrant workers' precarity in the host country's labour market. As argued elsewhere, it is important to develop a holistic understanding of

worker positionality (Coe & Jordhus-Lier, 2011; Carswell & De Neve, 2013). In this respect, Coe & Kelly singles out neoliberalism as this influential broad context which can help us to understand the positionality of migrants in the workplace by arguing that the 'deliberate' and 'strategic' reliance on 'foreign manpower' is part of the dominant neoliberal discourse of globalisation as 'an inevitable and virtuous growth dynamic' central to the nation-state's economic prosperity plans, along with the deregulation of various economic sectors' (2002, p. 348). In the same vein, Yeao's (2005) study found that the size of the transmigrant worker population grew in tandem with neoliberal restructuring processes that were designed to render labour more 'flexible' in relation to capital'. As a result, Chomsky has described neoliberalism as "the defining political economic paradigm of our time' (1999, p.40) whilst Thorsen & Lie has described it as "the dominant ideology shaping our world today" (2006, p.1) even after its reputation was severely damaged by the 2007–2008 World Financial Crisis (Stiegler, 2013; Dupuy, 2014). It is therefore in this context that the neoliberal business policy environment is discussed especially as it is highly implicated in the participation of migrants in aged care and the subsequent work conditions migrants encounter in the aged care sector that influence their workplace well-being (Courtois et al., 2015; Crowley & Hodson, 2014).

However, this is not the place to explore the historiography of neoliberalism in detail, as space and study objectives preclude that form of detailed examination. It is discussed here in so far as it is aligned with the critical perspective of this study designed to encourage a critical understanding of workplace well-being in a context of the dominance of a neoliberal mind-set that is increasingly shaping health care reform and care regimes (McGregor, 2001; Lutz & Palenga-Möllenbeck, 2011; Misra & Merz, 2015; Rushton & Williams, 2012) including management practices and employment relationships that are central to workplace well-being (Cohen, 2011; Courtois et al., 2015; Crowley & Hodson, 2014; Kalleberg, 2009; Shutes & Chiatti, 2012; Smith 2010).

The project of neoliberalisation which has been a dominant policy paradigm since the 1970s is centred on the promotion of production methods that are built around the concepts of cost minimisation and privatisation (Peck, 2010). In this respect, it has been observed that globally, the restructuring of the aged care sector resembles that which Peck & Tickell (2002) describe as neoliberalism's "roll-back" phase, characterised by reducing state expenditure on the aged care sector and encouraging private participation which is largely driven by the profit motive (see also Farris & Marchetti, 2017; Steinmetz, 2003).

The neoliberal fundamentals built around the idea of surplus value creation, profit maximisation, lean production, and commodification of everything (Harvey, 2007; Lindio-McGovern, 2012; Jensen & Prieur, 2016) explain why neoliberalism is implicated in feminisation of both migration and care, as well as the increased reliance on migrants to plug the aged care deficit in Western nations (Frazer, 2014; Lindo-McGovern & Wallimann, 2009). The migrant workers who are racialised, gendered, and often come from third world countries take on caring labour in host countries while transferring their own familial and community responsibilities to other even poorer caregivers, in an ever longer "global care chains" (Fraser, 2014, p.551). The net effect is to displace the care gap from the richer to the poorer nations or from the 'Global North to the Global South' (Benería, 2008; Hochschild, 2002). It must therefore be noted that the increased reliance on migrant care workers to address the aged care deficit is taking place in an environment in which the Western governments are finding it increasingly difficult to adequately financially support social services for its citizens (Jennings & Wasunna, 2005; Benería et al., 2012; Arlotti & Ranci, 2018; Fudge, 2021). The employment of migrants has therefore been described as a neoliberal inspired strategy of cost minimisation in the delivery of aged care services (Fellini et al., 2007; Misra et al., 2006; Rodriguez, 2004). The migrants enter a labour market that is designed to support the Western nations' desire to reduce the costs of providing services to its citizens. As a result, the range of neoliberalism inspire employment practices that the migrants encounter in the host country that are intended to generate surplus value are therefore generally not in harmony with work conditions that positively support workplace well-being (Vosko, 2010).

Form a well-being perspective, the western countries' reliance on migrants to close the care gap raises the issue of the social construction of migrant workers. The migrants are generally socially constructed, packaged, represented and commodified as reliable, docile, loyal, disciplined and low cost (Shubin & Findlay 2014; Cranston, 2016). Using neoliberal lenses, migrant workers, regardless of their gender, are therefore the ideal type of employee. They are an attractive commodity because they are more likely to accept low wages or to work difficult jobs that local-born employees who have labour mobility and better options than their migrant counterparts, refuse to perform (Fudge & Tham, 2017; Korhonen, 2017; Misra et al., 2006; van den Broek et al., 2019. The migrant workers are the ideal type of employee for a neoliberal dominated business policy environment because they can behave like any other commodity**:** flexible, have little voice in the way work is organised, cannot assert their work rights, and can be

cheaply remunerated and are easily disposable, (Harvey,2005, Peck, 2002; 2010). Compared to local-born unemployed workers, migrant workers operating in a neoliberal business context are more likely to sell their labour power far more cheaply for jobs that are dominated by poor conditions (O'Connor, 2010; Siebers & van Gastel, 2015).

At the same time, when considered from a gender perspective, it is also easy to see why neoliberalism is highly implicated in the discourse of the feminisation of both migration and care and the increased participation of women migrant employees in aged care jobs in the Western nations (Fraser 2014; Lulle, 2014; Eder, 2015; Jeronimo, 2020). It is argued that neoliberal strategies have led to an international division of care work that places the burden for care on the least powerful immigrant women workers (Heyzer & Wee,1994; Misra et al., 2006).

A quality that implicates neoliberalism in the feminisation of both migration and care is the minimal cost of sustaining a female dominated labour force. Migrant women are a cheap source of labour and that makes them a perfect match for the austerity neoliberal agenda (Harvey, 2007; Joppe, 2012; Peck & Tickell, 2002; Stuckler & Basu, 2013). In this regard, gender inequality has been documented as a driver for export competitiveness, because the segregation of jobs by gender tends to keep women's wages artificially low (Bamber & Staritz, 2016; LeBaron, 2015; LeBaron et al.,2018). Seguino calls this the "comparative advantage of gender disadvantage" (1997, p.12). For example, with reference to Philippine migrants, research concluded that their increase in immigrant labour is partly due to the global neoliberal demand for a class of service sector employees that are flexible and cheap (Liu, 2015). Characterised in this way, neoliberalism can be described as a big part of the structural marginalisation of migrants both within the home and host countries.

Numerous studies concur that neoliberalism impacts the quality of the work environment that influence workplace well-being (Breevaart, Bakker, Demerouti, Sleebos, et al., 2014; Breevaart, Bakker, Hetland et al., 2014; Breevaart et al., 2016; Kelloway & Barling, 2010; Leiter & Maslach, 2004, Kuoppala et al., 2008; Leiter & Maslach, 2004; Nielsen et al., 2017; Nielsen et al., 2010; Shannon & French, 2005; Simonazzi, 2009). With reference to the ARC sector, well-being and care workers, it has been argued that neoliberalism principles of austerity are implicated in the manner in which aged care facilities are managed and resourced, including the time allocated to caring for the residents, and the nature of employee and management relationships (Hoppania & Vaittinen, 2015; Shannon & French, 2005). For example, the neoliberal

economic belief of accomplishing more with less has permeated health care, resulting in proliferation of work design methods and employment cultures that promote lean staffing practices (Cohen, 2011; Lazonick, 2014; Lutz & Palenga-Möllenbeck, 2011; Porter & Kramer, 2011). The neoliberal model of care narrowly conceptualizes care as quantifiable, physiological tasks that are counted, measured, and sold as if they are packaged products to consumers of care (Knijn, 2000).

The result is unsustainably high patient-care provider-ratios that have effectively compromised the quality of care delivered in addition to being a strain on the well-being of service providers (Haultain, 2011; Kaine & Ravenswood, 2014; Productivity Commission, 2011; Productivity Commission, 2011). As a result, neoliberal forms of caring are largely associated with poor well-being outcomes (Coburn, 2000; Schrecker, 2016a, 2016b).

The neoliberal model of care therefore narrowly conceptualizes care as purely quantifiable, physiological tasks that are counted, measured, and sold to consumers of care as if they are packaged products (Daly & Armstrong, 2016; Knijn, 2000; Syed, 2016; 2020). With far reaching consequences for workplace well-being. It is argued that work intensification does not mesh well with the intangible nature of care work (Le Blanc 2017; Plummer, 2018; Selberg, 2013). Research has also established that those who work at high speed are far more likely to report negative health effects (Baines & Daly, 2021; Franke, 2015; Oxenbridge & Lindegaard, 2011) and experience stress and decreased job satisfaction (Braithwaite et al., 2007; Kontos et al., 2010; Willis, 2005; Zeytinoglu et al. 2007). As a result, the neoliberal inspired profit driven and cost minimisation practices have also resulted in a proliferation of work design methods such as work intensification or care speed-ups, and employment cultures that promote lean staffing practices in health care settings (Cohen, 2011; Lazonick, 2014; Porter & Kramer, 2011; Selberg, 2013). This neoliberal obsession with profit and market logics has also effectively converted the human resource management role to the "handmaiden of efficiency" designed to extract greater shareholder value (Dundon & Rafferty, 2018; Kaufman, 2015). As a result, this neoliberal ideology that has become so pervasive in the social discourses of aged care and employment relationships is criticised for inhibiting the implementation of employment relationship strategies that maximise the integration of worker goals for well-being (Kalleberg, 2011; Standing, 2011; Wacquant, 2014). As argued by Castles, "The neoliberal ideology of economic efficiency and shared prosperity masks the exploitation of labour on a global scale" (2011, p.311). The ability of employees to resist their employers' demands, for example, for them to display emotions which demonstrate a willingness to be always of

service – regardless of the toll on their personal well-being – are limited, because as commodities, the employees can easily be replaced (Crowley, 2014; Davies 2014, 2016; Harvey, 2005; Rousseau & Parks, 1993).

Neoliberalism is therefore partly a cause of the structural marginalisation that migrants are exposed to in the host country which shapes their migrant identities ultimately impacting their well-being. Structural marginalization generally results from structures and institutions that unevenly distribute benefits and burdens to different groups, and as a result, marginalize certain groups or people (Arrington-Sanderset al., 2020; Messiou, 2012; Petrou et al., 2009). It also denotes a situation where specific groups are perceived to be especially vulnerable to exclusion and stigmatisation (Bottrell, 2007; Brann-Barrett, 2011; Petrou et al., 2009). As a result, it is not surprising that structural marginalisation tends to radiate from both international and national policy levels, permeating the way individual organisations structure their organisational needs of productivity and the resources they use such as employees to achieve those objectives. There are therefore intersections between neoliberalism, migration, feminisation of both migration and care, temporary visa conditions, and the precarious and vulnerable migrant identities and poor ARC working conditions that are implicated in workplace well-being.

This critical theoretical broad-contextual analysis of neoliberalism and its connections to migration, feminisation of migration and care, including precarious work and precarious migrant identities, is designed to enable readers of this thesis to approach the interpretation of the primary findings of this study adequately equipped to make informed personal conclusions about the range of factors that are implicated in workplace well-being of migrant care workers.

It is in the context of the preceding discussion that this study investigated the following research questions

1. How does migrant identity impact workplace well-being?
2. How do work conditions affect migrant care workers' well-being?
3. How do workplace relationships affect migrant care workers' well-being?

Conclusion

The chapter has discussed the role of the broad context within which individual aged care organisations and employees interact. In this respect, this Chapter noted that aged care organisations exist in a broad neoliberal business policy environment context that shapes care regimes and by extension, what organisations can or cannot do to enhance workplace well-being (Barron & West 2017; Brennan et al. 2012; Stolt &

Winblad, 2009). The Chapter described the employment of migrants in ARC as part of a neoliberal cost-cutting and lean production agenda that is achieved partly by employing a class of increasingly flexible, cheap labour in the service sector at the global scale (Liu, 2015; Longhurst et al., 2019). The argument made in this Chapter is that the pillars of neoliberalism are not always compatible with work settings, work design methods, and terms and conditions of work that are ideal for supporting the physical, emotional, spiritual and social well-being needs of especially vulnerable employees, such as migrants doing precarious work (Rodgers, 2016; Kalleberg, 2009; Vosko, 2010). Neoliberalism is heavily implicated in the creation of precarious migrants who are unable to assert their work rights (Dutta, 2021; Eder, 2015; Kalleberg & Hewison, 2013). Additionally, it was argued that understanding well-being in the context of migrants requires an examination of the role played by the migrants' pre-migration circumstances in their decisions to migrate including taking jobs that are commonly shunned by locals because of their poor working conditions (Moyce & Schenker, 2018; Mucci et al., 2019a, 2019b; Ronda et al., 2016). There are therefore intersections between neoliberalism, migration, feminisation of both migration and care, temporary visa conditions, and the precarious and vulnerable migrant identities and poor ARC working conditions that are implicated in workplace well-being. Whilst the focus of this Chapter was on the broad neoliberal business policy environment and its connections with feminisation of both migration and care, and precarities associated with migrant identities, the following Chapter Four examines a much narrower context of the New Zealand Aged Care sector.

Chapter 4: New Zealand Aged Care Sector

Introduction

'Things are known in two senses: known to us and known absolutely. Presumably, we must start from what is known to us' (Aristotle, 1976)

The previous chapter provided a critical perspective of the broad context of ARC and migrant participation in relation to workplace well-being by analysing neoliberalism business policy environment and its intersections with feminisation of both migration and care including its role in engendering migrant identities that are encapsulated in terms such as 'precariat' (Standing, 2011) or 'outsider' (Carling et al.,2014) with a 'precarious migrant status' (Fudge, 2012;Dyer et al., 2011; Anderson,2010) doing 'precarious employment' (Fudge, 2012) and leading 'precarious lives' (Pye et al., 2012)**.** The previous Chapter has therefore provided insights into the range of conditions within the broad neoliberal business policy environment that may shape workplace factors that impact migrant care workers' well-being. This broad policy context needs to be supported by an examination of the specific context of this study; the New Zealand Aged Care Sector (NZARC). This Chapter Four (New Zealand Aged Care Sector**)** therefore builds on the previous chapters by providing an overview of key characteristics of the ARC sector in New Zealand. Through this examination, it is found that the composition of the ARC supply sector reflects the presence mostly of privately owned, Profit for profit, and not-for-profit providers (Broad et al., 201; Frey et al., 2016). This composition of ARC providers aligns well with the discussion in Chapter Three which noted that neoliberalism had become the dominant influence structuring economic, social and political relationships in contemporary society (Chomsky,1999; Evans et al., 2005; Harvey,2004, 2007; Schwiter et al., 2018). This chapter also extends the previous discussions in Chapters One and Two about migrants as vulnerable people doing precarious jobs (Castles, 2010, 2011, 2015; Strauss & McGrath, 2017). Chapter Four also examines the complex expressions and interplay of factors that impact migrant identity such as migrant status, legality, race and their influence on migrants' entry into aged care jobs that are characterised by poor conditions of work (Martin, 2007).

Care gap phenomenon and anatomy of the aged care job

To develop a better understanding of the New Zealand ARC context, it is important to situate it within the global phenomenon commonly referred to as the care deficit. This is because it is essentially the care deficit which has largely contributed to the increased deployment of migrants as care workers – a key focus of this present well-being study

(Fine & Mitchell, 2007; Walsh & Shutes, 2013a). In this thesis, the term 'migrant' is used to refer to people born outside of the country of current residence (UN Population Division, 2018). The term 'migrant care worker' therefore refers to those born outside New Zealand where they are now employed as aged care workers.

The 'numerical ageing' (Jackson, 2011, p.2), or the absolute increase in the numbers of those aged 65 and over is a result of a combination of factors such as declining fertility, improved access to better health, improved living conditions, a growing consciousness about healthy living and increasing life expectancy (Bascand, 2012; Christensen et al., 2009; Hussein & Ismail, 2017; Statistics New Zealand, 2010). From 2015 to 2050, the proportion of the world's population aged 60 years or more will nearly double (from 12% to 22%) with profound consequences for health care systems (World Health Organization, 2015). According to World Population Prospects 2019 (United Nations, 2019), by 2050, globally, 1 in 6 people will be over the age of 65, up from 1 in 11, in 2019.

Table 4.3 Number of persons aged 65 years and over by geographic region, 2019 and 2050

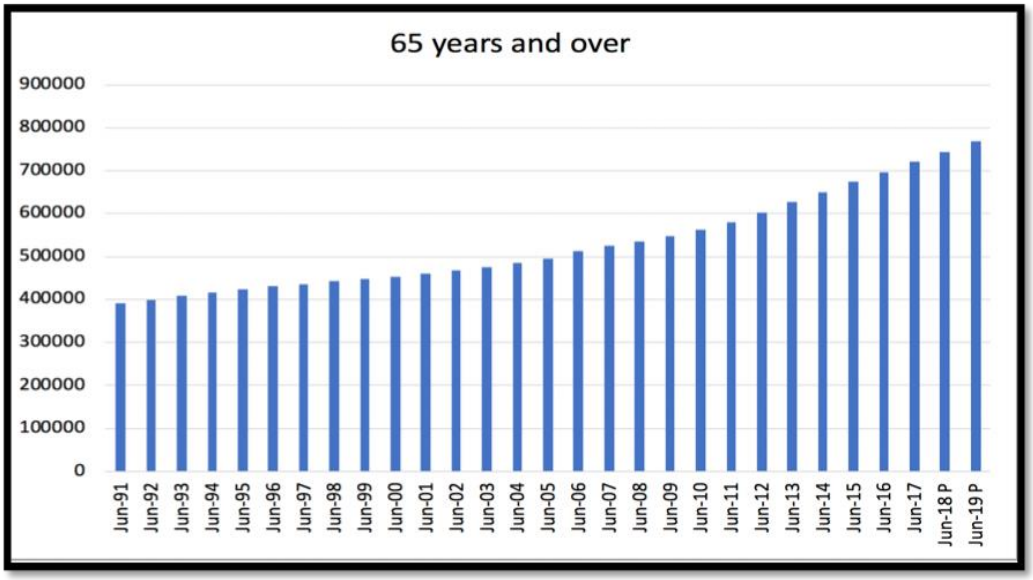
Region	*Number of persons aged 65 or over in 2019 (millions)*	*Number of persons aged 65 or over in 2050 (millions)*	*Percentage change between 2019 and 2050*
World	**702.9**	**1548.9**	**120**
Sub-Saharan Africa	31.9	101.4	218
Northern Africa and Western Asia	29.4	95.8	226
Central and Southern Asia	119.0	328.1	176
Eastern and South-Eastern Asia	260.6	572.5	120
Latin America and the Caribbean	56.4	144.6	156
Australia and New Zealand	4.8	8.8	84
Oceania, excluding Australia and New Zealand	0.5	1.5	190
Europe and Northern America	200.4	296.2	48

Source: United Nations, Department of Economic and Social Affairs, Population Division, 2019

The demographic ageing of New Zealand society, as elsewhere in the developed world, has witnessed a significant rise in the proportion of older people (aged 65 years and over) in the population (Badkar & Manning, 2009; Bascand & Dunstan, 2014; New Zealand Aged Care Association, 2018). Table 4.1 also shows that the number of

people in Australia and New Zealand who are 85 years old and older – often called the 'oldest old' and known for needing intensive service utilisation – is also increasing, as is the case in several other countries (Fujisawa & Colombo, 2009; Gaughler & Kane, 2015; He et al., 2016). The 2018 census found that there were 23 people aged 65 years and over (65+) for every 100 adults aged 15-64 years, as was the case with the 2013 Census (22 per 100) (Statistics New Zealand, 2018).

Table 4.4 Population aged 65 years and over-June 1991- June 2019



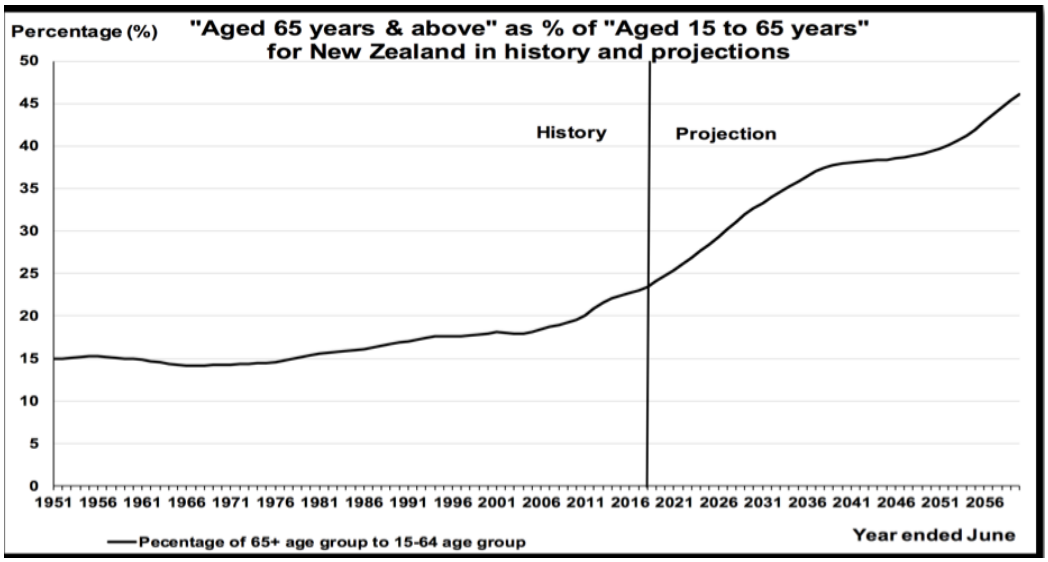
Source: NZ Statistics, 2019

It has also been found that New Zealand has a higher ratio of people in residential care than most other countries (Broad et al., 2014; Broad, Ashton, Lumley & Connolly, 2013). Using a lifetime perspective, it is predicted that if all factors remain the same, 47% of all the New Zealanders aged 65 or more will at one time require residential care and that this percentage will increase to two thirds of those who live to be 85 and over (Broad et al., 2015; Meagher, 2016). It is also projected that the increase in number of those aged 65 will result in a sharp rise in demand for ARC services into the future (St Andrew's Village & The Salvation Army's Social Policy & Parliamentary Unit, 2017; Grant Thornton, 2010; Lazonby, 2007; Careerforce, n.d.).

A significant concern arising from these demographic ageing trends is the impact on New Zealand's ability and capacity to support older New Zealanders with the appropriate level of care when and where they require it. The rise in the number of older people requiring care raises questions about workforce availability and adequacy, as well as health expenses (Bell, 2019; World Bank, 2020). As shown in Table 4.3, the

demographic old-age dependency ratio (people aged 65 or above, relative to the working-age population) is projected to continue increasing.

Table 4.5 Age Dependency Ratio: Older Dependents to Working-Age Population for New Zealand

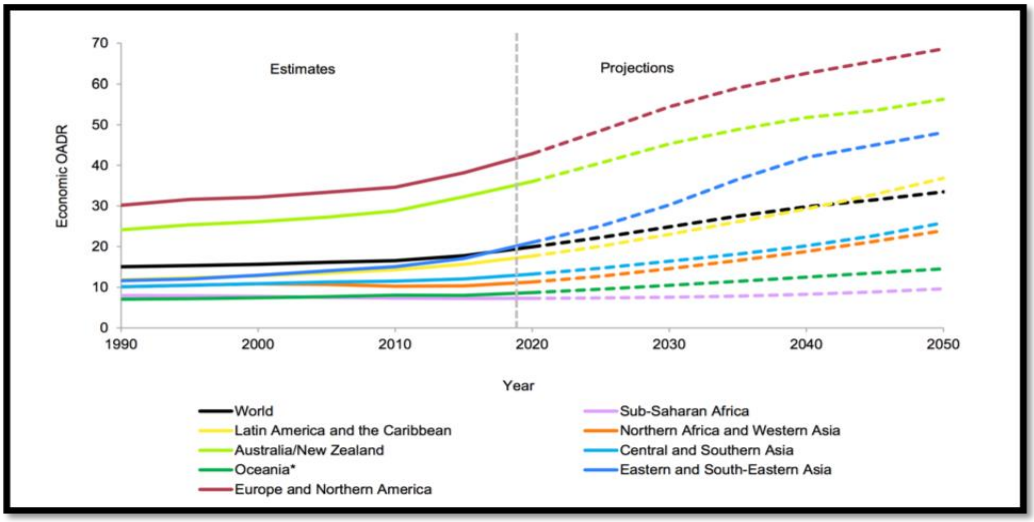


Data is shown as the proportion of dependents per 100 working-age population.

Source: Bell, 2019

The old-age dependency ratio is anticipated to increase in all regions of the world, especially in Eastern and South-Eastern Asia, Latin America and the Caribbean (UN, 2019).

Table 4.6 Projected economic old-age dependency ratios by region, 1990-2050



Source: UN, 2019

Table 4.4 presents the estimated and projected old-age dependency ratio for the world and by region. Since the 1990s, the old-age dependency ratio has continuously increased across all regions, although the level and speed of this increase varies. In

2050, the global old-age dependency ratio is projected to increase to 28 older persons for every 100 working age persons. In Europe and Northern America, there were 30 older persons per 100 working age persons in 2019, a ratio that is projected to rise sharply, reaching 49 in 2050.

In Australia and New Zealand, the old-age dependency ratio is projected to increase from 27 in 2019 to 42 in 2050. Currently, Europe, Northern America, Australia and New Zealand have the highest economic old age dependency ratio of 43 and 36 respectively (UN, 2019). These old age dependency ratio figures are significant when one considers that by 2026, it is estimated that ARC services will be needed by between 12,000 and 20,000 more New Zealand residents and that this will result in a sharp increase of between 50% and 75% demand for workers (full time equivalents) (MBIE, 2018). It is, however, ironic that whilst the increased life expectancies and the continued growth of the older population have increased the demand for aged care support, falling birth rates have, among other reasons, reduced the supply of workers who can help meet this demand (Badkar et al., 2009; Boyd et al., 2011; Grant Thornton New Zealand Limited, 2010; New Zealand Labour, Green Party of Aotearoa NZ, Grey Power, New Zealand, 2010; Soraceno, 2010; World Bank, 2020).

In New Zealand, as is the case in other Western nations, the shortage of labour which has created a care deficit is largely credited with the increased role of migrants in ARC (Grant Thornton, 2010; Kaine & Ravenswood, 2014; Kiata, et al., 2005; Ravenswood & Douglas, 2017; Walsh & Shutes, 2013a; 2013b). Besides falling birth rates, the other factors accounting for the labour shortage in ARC include an ageing aged care workforce, as well as unattractive working conditions (Beard & Bloom, 2015; Ravenswood, Douglas & Haar, 2017; Rouxel et al., 2016; Sutcliffe & Dhakal, 2018). These working conditions have largely acted as barriers to recruiting young workers into the aged care sector.

Worldwide, immigrant workers experience poor occupational risks that negatively impact their well-being (Takala et al., 2014). The other negatives about aged care jobs in New Zealand, as is the case in the rest of the world, is that they are not only poorly paid, with poor security and few training opportunities or opportunities for advancement, but the industry is also highly feminised (Charlesworth & Heap, 2020; Meagher, 2016). The concept of a highly feminised care sector emphasises the negatives associated with jobs that are dominated by women employees. For example, undervaluation and low pay are likely to occur in jobs and industries that are highly feminised (Acker, 2012; Austen & Jefferson, 2015; Austen et al., 2013; Grimshaw &

Rubery, 2007). Although the characterisation of jobs as ‘feminine’ might make them more attractive to some sections of the labour market, generally feminised jobs tend to be undervalued in addition to having more negative associations compared to jobs predominantly done by men (Ravenswood & Harris, 2016). Care work internationally is low paid (New Zealand Human Rights Commission [NZHRC], 2012; Ravenswood & Douglas, 2017). The reference to care jobs as ‘woman’s work’ reflects a gendered undervaluation of care work (Charlesworth & Heap, 2020; Meagher, 2016; Ravenswood & Harris 2016; Ravenswood et al., 2021).

Additionally, the characterisation and positioning of care work as low status provides a justification for the low pay the care workers receive (Ravenswood & Harris, 2016; Meagher, 2016) thereby perpetuating the low status image of care workers (Ferguson, 2013; Ferguson & Folbre, 2000; Folbre, 1995; Ravenswood et al., 2015). Meagher (2016) argued that the feminisation of care work effectively under-recognises the range of skills needed to provide quality daily elder care. This lack of recognition results in care workers being underpaid. Additionally, since these skills are not recognised, the recruitment process also does not pay attention to the skill level of job applicants.
It is also argued that aged care work environments are also a risk factor for violence, including patient violence or aggression (Di Martino, 2003; Ravenswood et al., 2017; Schablon et al., 2018). In healthcare settings, violence includes any incidence of threatening verbal, sexual and physical threats from the patient and the relatives of the residents (Anderson & West, 2011). It has also been observed that the aged care sector tolerates and expects abuse from clients as part of the job (Delp et al., 2010; NSWNMA, 2016; Ravenswood et al., 2017), that violence has been ‘normalised’ (Brophy et al., 2018), especially in cases involving dementia residents (Copeland & Henry, 2017). Research has also shown that low level direct care employees are at higher risk of patient abuse than higher level staff such as doctors or nurse practitioners (Pompeii et al., 2015; Ravenswood et al., 2017).

The precarious character of ARC work has also contributed to the local New Zealand-born employees’ lack of interest to apply for aged care vacancies. The 2012 Caring Counts Inquiry (McGregor, 2012) found a high prevalence of poor working conditions in New Zealand ARC, such as insecure hours of work, poor wages and a heavy workload that increased precarity of especially the female care workers. Several studies show that low pay not only undermines aged residential care workers’ status and living standards, but also deters people from working in the ARC sector (Meagher, 2016). However, the significance of pay in attracting and retaining especially New Zealand-

born workers in the aged care sector should not be overstated. This is demonstrated by the 2017 Pay Equity Settlement described by Douglas & Ravenswood as a "significant step for New Zealand in re-valuing low paid female dominated occupations that are and have traditionally been viewed as women's work" (2019b, p.4). On one hand, the 2017 Pay Equity Settlement removed wage discrimination based on gender, as well as linking pay rates to qualifications (Douglas & Ravenswood, 2019b). On the other hand, the 2017 Pay Equity Settlement legislation has not resulted in a surge in New Zealand-born workers applying for aged care job roles (Douglas & Ravenswood, 2019b; Wallace, 2018). This indicates that higher wages do not necessarily mean the job is more attractive.

Compounding the problem of the aged care labour supply deficit, is that increasingly, aged care patients have much higher health needs, thereby putting unprecedented pressure on care providers (Boyd et al., 2011; Lazonby, 2007; Meagher, 2016; NZNO-E Tū, 2019). As argued by Burrow et al. (2017), "The complexity and acuity of a client population requiring specialised care challenges the constraints of care contract expectations and creates significant difficulties for both registered nurses and healthcare assistants" (p.1). Some studies have identified employee skill-related challenges associated with providing person-centred care for residents with complex care needs (Meagher, 2016). In this context, a 2019 NZNO-E TŪ Report criticised the NZ Standard Indicators for Safe Aged Care and Dementia Care for Consumers SHNZ HB 8163:2005 Act that guides staffing ratios in aged care. The study found that the SHNZ HB 8163:2005 Act's staffing stipulations translated into 6 minutes of care per hour per resident. The report found that the low staff levels and the higher needs of more frail residents meant that staff was put into an ethical dilemma of deciding who to give care to. The report concluded that the staffing standards are dated and fail to reflect the needs of residents. Therefore, the limited time allocated to personal care is not in harmony with the New Zealand ARC sector's concerns for person-centred care. The WHO has argued that person centred care,

> "…is grounded in the perspective that older people are more than vessels of their disorders or health conditions. They are individuals with unique experiences, needs, and preferences, dignity and autonomy are respected and embraced in a culture of shared decision-making" (2015, p103).

Baines & Armstrong (2018) have however, argued that those who advocate client-centred and person-centred care,

> "…rarely mention, let alone engage meaningfully, with the larger social context of austerity policies, underfunding, rushed and overburdened care staff, or with models of management that focus on medical care, cost savings and efficiencies rather than on robust social care and supports" (p.3).

In this respect, Meagher (2016) found that not all New Zealand ARC workers had the skills required to deliver such patient centred care.

Finally, another problem causing labour shortages is that most of the caregivers are also ageing (Burrow et al., 2017; Callister et al., 2014; Kiata et al., 2005; New Zealand Ministry of Health, 2014). New Zealand has one of the highest rates of employment for people aged over 55 years of all OECD countries (Bentley et al., 2015). An ageing aged care workforce presages a loss of workers through retirement as well as an inability to continue performing the hard tasks required of aged care work (Badkar, 2009; Fujisawa & Colombo 2009a, 2009b; Hensen & Yeabsley, 2013). As the generation of 'baby boomers' are now reaching retirement age, the number of workers leaving aged care continues to rise. The workforce impact of this phenomenon on the aged care sector is significant because being a service industry, its delivery relies extensively on 'person-power rather than technology' (Graham & Duffield, 2010, p.44).

The New Zealand aged residential care characteristics

The care and housing of people requiring residential care in New Zealand is undertaken in several ways. Publicly provided ARC is the legal responsibility of District Health Boards [DHBs] (NZ Treasury, 2013). DHBs are legally responsible for funding residential care services for older people. The DHB meets this legal obligation by using the residential care subsidy to contract rest home and hospital owners (NZ Treasury, 2013). The DHBs were mandated with making adequate availability of contracted care beds for all those meeting entry requirements for residential care (NZ Treasury, 2013). The assessment of eligibility is carried out by the DHB or on its behalf by the Needs Assessment Service Co-ordination Agency (NASC) (Ravenswood, 2011). ARC is therefore publicly funded but based on asset and income assessment (NZ Treasury, 2013).

It has however been noted that government funding is failing to match the rise in demand for ARC services (New Zealand Labour Party & Green Party of Aotearoa New Zealand with Grey Power, 2017). In 2013, of the around 30,000 people in residential care, around 5,000 of them paid the full cost of their care (New Zealand Treasury, 2013). A further 4,000 had assets over the threshold and paid the maximum

contribution. This gave them access to higher-level subsidised care. The remainder qualified for the residential care subsidy (New Zealand Treasury, 2013). The Health Quality and Safety Commission New Zealand reports that 73, 000 people lived in ARC in New Zealand during 2018/19. These figures underline the significance of human capital development and health care resources to address the needs of older persons in residential aged care.

New Zealand ARC includes the following types of aged care provided in a rest home or hospital:

Table 4.7 New Zealand model of aged care

1. Rest home care: These provide care for older people who can manage some daily tasks but need help with personal care and who would find it difficult to live safely in their own homes.
2. Continuing care (hospital): Provides care for people who have significant medical problems or disability. They need healthcare from registered nurses and support from others to move about.
3. Dementia care: Provides care for people suffering from dementia or other mental illnesses and who could be a risk to themselves or others.
4. Specialised hospital care (psychogeriatric care): These are secure units that care for people who have difficult behavioral problems, including severe dementia or addictions, and need a high level of specialist nursing care.

Source: Ministry of Health, 2020, n.p)

ARC providers operate within a fixed-price environment, with different fees for different levels of care; rest-home care being the lowest level (NZ Treasury, 2013). The ARC provider sector has also changed over the past 20 years. These four categories that reflect an existing funding model for ARC facilities were developed in the 1990s. However, a review undertaken by Ernst and Young New Zealand (2019) states that the existing four categories of the funding model no longer accurately reflect the diverse needs of aged care people with 90% of residents spanning across two care categories. The scope of this thesis is ‘formal care’ offered in the Rest Home dimension of the New Zealand ARC sector.

The composition of the ARC supply sector reflects the presence of mostly privately owned and not-for-profit facilities. There are nearly 700 New Zealand aged care

residential homes, of which 61% are privately owned, whilst non-profit organisations own 20% of them, 19% are publicly listed and 1% have other types of ownership (New Zealand Aged Care Association; 2014; New Zealand Labour Party & Green Party of Aotearoa New Zealand with Grey Power, 2017). Figure 4.1 represents the percentage of ARC providers in the different ownership segments.

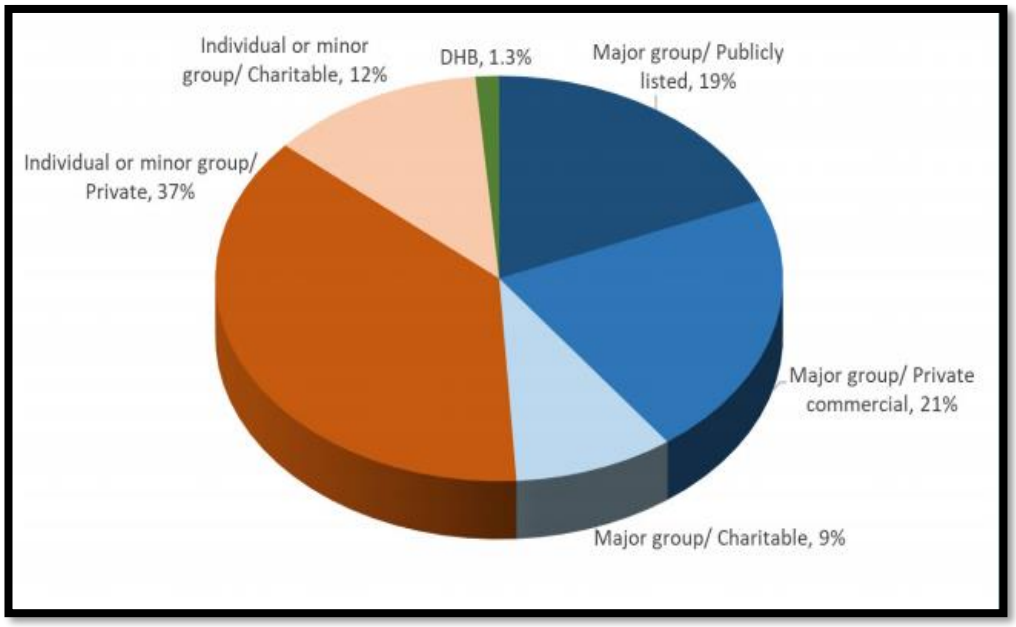


Figure 4.4 Percentage of ARC facilities in ownership segments
Source: NZACA, ARC Industry Profile 2019-20

The companies holding the largest market share in the New Zealand ARC industry include Bupa Care Services NZ Limited, Ryman Healthcare Limited and Oceania Healthcare Holdings Limited. Providers sometimes offer more than one type of care within the same property (Ernst & Young, 2019). For example, it is common for an aged care facility to offer a combination of rest home and hospital beds. These mixed-use aged care facilities constitute 44% of care facilities and supply 45% of beds (McDougall, 2018).

New Zealand regulation and policy oversight of aged care services

The picture that has been established so far is one of an aged care sector that is under stress and in need of commensurate policy responses to adequately address the needs of both the aged care patients as well as those providing care. Considering that the focus of this thesis is well-being and work experiences, the section below discusses the New Zealand legal environment. There is a specific focus on the laws governing how employees are engaged and managed in the aged care work environment. This is important in that it contextualises the aged care working environment and subsequently their well-being in relation to their work experiences.

The current means for regulating labour standards for the aged care workforce includes general employment legislation, legislation specific to the care and support workforce, and auditing and accreditation criteria which are outlined in the Health and Disability Safety Act 2001. Legislation that determines minimal standards for employment in New Zealand generally include The Employment Relations Act 2000. This Act addresses various employee related issues, such as minimum employment rights and working hours (Section 67C), holidays and leave (Section 69J) and breaks (Sections 69ZC, 69ZD, and 69ZE) (New Zealand Legislation, 2019). The act clearly instructs employers to treat employees fairly and to provide them with a written employment agreement that clearly describes employee's entitlements. Section 104 of the Employment Relations Act addresses discrimination on the grounds of sex, marital status, religious beliefs, ethical beliefs, colour, race, ethnic or national origins, disability, age, political opinion, employment status, family status and sexual orientation and is further addressed by the Human Rights Act 1993 (HRA) (New Zealand Legislation, 2019).

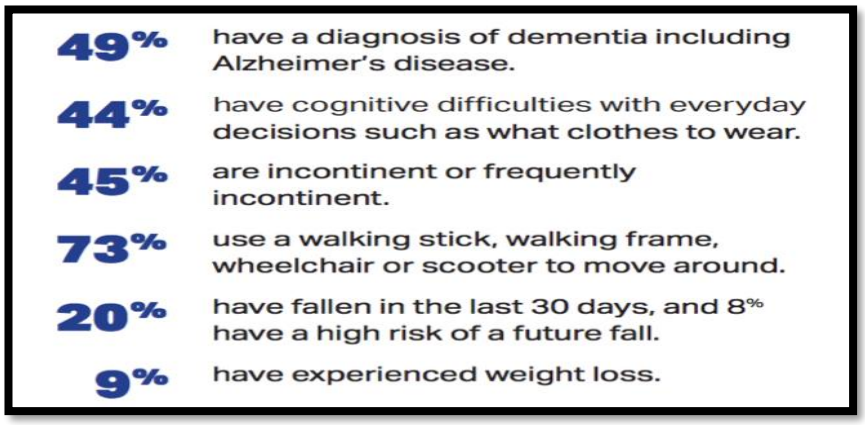
The other legal instrument that promotes the rights of the employees includes the Health and Safety at Work Act 2015. This Act explains the approved codes of practice, and safe work instruments. Section 211 (regulations relating to health and safety) explains employees' rights regarding working in a place where risks to health and safety are adequately managed. The health and safety issues are critical to workplace well-being and from a policy perspective, the New Zealand government is concerned about the welfare of employees. However, in general, there is always tension between policy rhetoric and practice. In this regard, to enhance understanding of migrant care workers' well-being, it is important to establish the migrants' perceptions about the extent to which the New Zealand policy and legal framework is matched by the practice in aged care facilities and then consider the subsequent well-being impacts. In addition to the Minimum Wage Act 1983 and the Equal Pay Act 1972, is the Care and Support Workers (Pay Equity) Settlement Act 2017 which prescribes training opportunities and hourly wages for aged care (and the disability sector) for a period of five years.

The other legal instruments relevant to ARC includes the New Zealand Ministry of Health Staffing Regulations for ARC Facilities 2004, the Age-Related Residential Care Contract, Section D17 Human Resources, sub-clauses D17.1 and D17.2 set some of the conditions that govern care provision in Rest Homes. Section D.17.1 of the ARRC Contract requires that the facility must be adequately staffed to effectively address the health and personal care needs of all the subsidised residents. Subclause D17.2 states that in every facility where there are:

i. 10 or fewer subsidised residents, there must be a care staff member on duty at all times
ii. up to 29 subsidised residents, there must be one care staff member on duty and one care staff member on-call at all times
iii. more than 30 subsidised residents, at least two care staff members shall be on duty at all times
iv. more than 60 subsidised residents, at least three care staff members shall be on duty at all times (Ministry of Health, 2004, p.17).

If the aged care residents are largely capable of doing some basic personal care on their own, the Sub-clause D17.2 ratio stipulations could be considered very reasonable in terms of governing workload and the quality of care received by the aged care patients. However, these stipulations are not based on the condition or status of the patients receiving aged care. For example, there is evidence that the residents enter residential care at a later age when they have multiple long-term conditions and disability-related challenges that requires specialised, continuous care (Meagher, 2016; Boyd et al., 2011; NZNO-E Tū, 2019; Parr-Brownlie et al., 2020). Such residents require intensive care**.**

Table 4.8 Vulnerabilities of residents in ARC



Source: The Health Quality and Safety Commission, 2020

These percentages show that most of the residents have limited ability to self-care and therefore require a lot of assistance and confirms observations that suggest that the elderly are entering ARC at an older age, and with higher frailty and are therefore more vulnerable (Boyd et al., 2011; Ernst & Young New Zealand, 2019; WHO, 2015). Previous studies established that there is a need for extra time allocation to assist in adequately meeting the care needs of such patients (Felix et al., 2009). In this context,

a New Zealand based study (Hales et al., 2019) argued that the current staffing ratios for residents who require hospital level (continuing) care across the 24-hour period are not sufficient for older adults with extreme obesity (2 hours of Registered Nurse time per day per resident with high acuity needs and 2.4 hours of Health Care Assistant support). The study established that the current practice standards of one caregiver per 45kg of patient weight when using safe moving and handling equipment does not address the needs of patients who may be 150kg or more. Staffing ratios for such patients need to be higher (Hales et al., 2019).

The legal statutory instruments that have been presented here reflect the presence of a strong legal regulatory environment designed to safeguard the fair treatment and protection of all employees regardless of gender, race or nationality. This is especially important considering that globally; migrant care workers are generally among the most vulnerable members of society suffering from a lack in legal protection (Bar-Mor et al., 2012; Hobson & Bede, 2015; Standing, 2011). Workers who lack legal protection are most vulnerable to poor health outcomes (Moyce & Schenker, 2018).

Migrant employment in the NZ aged-care sector

As previously mentioned, the New Zealand ARC sector, as is the case with other Western nations, has not managed to attract adequate numbers of local-born employees to address the growing care gap, ultimately resorting to the employment of migrant care workers (Callister, 2015; Calliste et al., 2014; Ngocha-Chaderopa & Boon, 2016). As of January 2018, there were around 16,000 workers in New Zealand in-home care (New Zealand Now, 2019a; 2019b). The actual number of people employed as care workers is difficult to establish. In 2018, the Ministry of Business, Innovation and Employment (MBIE) estimated there were around 22,000 caregivers and 5,000 nurses who were working in ARC facilities. In total there were 33,000 caregivers employed in aged care in New Zealand (MBIE, 2018). As of February 2020, the New Zealand Aged Care Association Chief Executive Simon Wallace said that there were 30,777 aged care workers and that around 6000 of them were migrants (RNZ Daily Newsletter, 2018).

This part of this chapter examines the policy environment including use of migration law to address the New Zealand residential labour shortages. For the purposes of this thesis, the term migrant is used to refer to people born outside of the country of current residence (UN Population Division, 2018). The term ‘migrant care worker’ therefore

refers to those born outside New Zealand where they are now employed as aged care workers.

The migrants' participation in the New Zealand ARC sector is happening within the context of a care job that is failing to attract enough New Zealand-born workers to fill the aged care job vacancies (see Ravenswood & Smith; 2017; Ravenswood et al., 2015; Ravenswood & Douglas, 2014, 2016; St Andrew's Village & The Salvation Army's Social Policy & Parliamentary Unit, 2017). Even though the migrants participating in residential care are increasing, statistically, they still constitute a minority of the aged care workforce (Ravenswood & Smith; 2017). The exact number of migrants working as care workers has not been established, although inferences can be made from NZ Census data, as well as studies by Callister et al. (2014) for example. Nearly 20% of the aged caregivers' workforce between 1991 and 2001 were overseas born, a figure that increased to 31% by 2013 (Callister et al., 2014).

Migration pathways for care workers: Visa categories

Since the 1986 Immigration Review and the subsequent 1987 Amendment to the Immigration Act, migration has continued to be a policy concern for successive New Zealand governments in attracting the 'desirable migrant' that could fit its "economic and social cohesion objectives" (Simon-Kumar, 2015, p.1173; also see Howe et al., 2019). For many years, New Zealand has used a temporary work visa, namely 'The Essential Skills Work Visa' to enable entry of temporary care workers. The Essential Skills Work Visa was a product of the Essential Skills Policy (ESP) which was launched in 2008 (Ministry of Business, Innovation and Employment, 2019a, 2019b). However, the Essential Skills Visa has its roots in the 1991 amendments to immigration policy and the Immigration Act which allowed for the introduction of a 'points system' like those used in Canada and Australia (Burke, 1986; Trlin, 1997). This policy captured policy makers' awareness of the extensive labour shortages across a wider skill spectrum and created a new framework for the migration of temporary care workers to New Zealand (Department of Labour Report, 2010). Over time, the Essential Skills Policy resulted in more care workers entering New Zealand through the major occupation group 'Community and Personal Service Workers' (New Zealand Government, November 2015, Annual Report). By 2014/15, this group accounted for 11% of the temporary labour migration programme (Ministry of Business, Innovation & Employment, 2015). The other group to have benefited from the Essential Skills Policy between 2014 and 2015 is the 'aged and disability carers' of which 2537 visas were issued. The other groups to benefit were 'nursing support workers' of which 1122 and

400 visas were issued respectively (Curtain, 2016). These statistics are evidence of the increased participation of migrants in ARC service delivery in New Zealand.

Criticism has however, been levelled against this essential skills visa entry system for care workers. For example, Howe et al., (2019) described the New Zealand migration pathway for care workers as "… vexed and contingent, producing precarity for workers and embedding low wages and conditions in the care sector…" (2019, p.216). Although there is limited data, the New Zealand ARC sector has addressed its labour shortage challenges by employing temporary migrants on different types of visas including partners, international students and working holiday visa holders. Some of the migrant care workers come into the country through the international student visa. The student visa is primarily for education, but it also allows its holders to work 20 hours during term times and as many hours as possible during scheduled breaks (New Zealand Immigration, n.d). However, the visa conditions for students enrolled in master's degrees by research or doctoral degree programmes awarded by a New Zealand tertiary institution have no restrictions on the hours they can work (New Zealand Immigration, n.d). Partner of a Worker Work Visa, Partner of a New Zealander Work Visa and Partner of a Student Work Visa allows the holders to work fulltime (New Zealand Immigration, n.d). There is, however, no available information on the actual number of partners of students, holiday makers and international students who are employed in New Zealand's ARC sector.

The visa changes that the New Zealand government announced in 2017 are important to this study's focus on migrant care workers' well-being. These April 2017 changes which came into effect in August 2017 regarding the Skilled Migrant and Essential Skills Visa categories have substantially impacted the employment of migrant workers in ARC and other related sectors (New Zealand Aged Care Association, 2017; The Salvation Army Social Policy & Parliamentary Unit, 2017). For example, the Essential Skills visa category will in future be granted only for three consecutive one-year periods. After that the applicant must first exit New Zealand for at least 12 months before they are eligible to reapply. Previously there was no stand-down period in which employees were required to leave New Zealand. The changes are aligned with New Zealand's move to a 'Kiwi first' immigration policy consistent with similar protectionist immigration policies by governments around the world (BAL, 2017).

On 16 September 2019, the New Zealand government announced further changes that will be rolled out over the next 18 months, starting November 2019. The government is

introducing a new single employer-assisted temporary work visa that will replace the current six visa categories with one temporary work visa. To be replaced are the Essential Skills, Approval in Principle, Work to Residence – Talent (Accredited Employer), Work to Residence – Long Term Skills Shortage List Occupations, Silver Fern Job Search and Silver Fern Practical Experience. These changes are designed to make it easier for employers to recruit temporary employees in line with their labour requirements.

However, a prominent issue in relation to this new visa is that the employers will continue to have control of the recruited employees since the visas are going to be tied to a single employer. In relation to these changes, McDougal's research found that "among care facilities with caregivers on visas which expired in the previous year, 63% found it has become more difficult to recruit and retain caregivers on visas, 17% found there had been no change and only 3% thought this had become easier" (2018, p.42). This resonates with the NZCA's (2017, n.p.) view that "The changes will seriously affect valuable labour force, disrupting continuity of care, creating higher churn and cost for employers and hindering training and up-skilling". From the perspective of well-being and migrant workers, the migrant policy shift to a more 'kiwi first' focus has the potential to impact negatively on their tenure and sense of security. The changes will potentially worsen the tenuous residency status of migrant healthcare assistants because occupations commonly employed in the ARC sector will not be successful in applications for a Skilled Migrant visa. This is because they are unlikely to meet the Level 3 status or the higher income threshold as skilled occupations or positions (The Salvation Army Social Policy & Parliamentary Unit, 2017). It has also been argued that the "expectation of a temporary stay can result in a lack of social attachment and a preparedness to forego social pleasures" (Anderson, 2010, p.305).

Another significant concern for migrants' well-being is the impact of visa changes on employee-employer relationships. The tied nature of the work permit under the Essential Skills Policy, which has also been retained in the new single temporary visa, effectively tilts the power of balance to the side of the employers. This makes it realistically difficult for migrant care workers to complain against any exploitative practices performed by their employer. The employer therefore wields extensive influence on whether the migrant care worker's application for visa extension or permanent residency a success is or not. These views are echoed by Anu Kaloti of the New Zealand Migrant Workers Association when she said that tying the visa to a single employer is going to contribute to continued worker exploitation (Scotcher, 2019). The

recent changes have completely constrained employees because their pathway to permanent residency is now inextricably interlinked with their ability to maintain their employment relationship with a single employer. This is also echoed by findings of a New Zealand study by Lovelock & Martin (2016) which uncovered that migrant care workers were under constant pressure "to demonstrate that they met the moral and ethical requirements of permanent residency and ultimately citizenship" (2016, p.379). These migrant care workers also feared that they would never obtain permanent residency if they did not show greater emotional commitment and citizenship (Lovelock & Martin, 2016). The visa change could be characterised as, to borrow Costello's words, "an additional layer of dependence, created by the tying of migration status to employment within employer-sponsored visa schemes" (2015, p.139) which intensifies the inherently unequal nature of employment relationships (Freedland & Kountouris, 2011; Howe et al., 2019). This power imbalance resulting from the visa changes is likely to cause further instability for the migrants and their families as well as limiting the extent to which employers would take an interest in the training and development needs of their migrant care workers (The Salvation Army Social Policy & Parliamentary Unit, 2017).

An argument could therefore be advanced that this visa change is more likely than not to produce and reproduce 'precarious workers' over whom employers have particular mechanisms of control. The new visa changes have restricted opportunities for migrants, worsening their vulnerability and reducing their welfare.
The visa changes are however not all gloom and doom for migrant care workers. From a workplace well-being viewpoint, the visa changes have enhanced the social well-being of the migrants by providing an allowance for the lower-skilled workers to bring their relatives to New Zealand. In response to this change, Anu Kaloti from the Migrant Workers Association noted that,

> "We feel it's important for families to stay together, especially when they're trying to make a go of life in a very new environment, a new country, so it's important the families are not kept apart." (Scotcher, 2019, n.p.).

Family support in the new environment is likely to have far-reaching implications for their well-being at home and at work. This is aptly captured by Hochschild's (2000a) "care chain" concept which describes migrant women who immigrate to find jobs as care workers leaving the needs of their own families unattended That the new visa changes allow migrants to bring their families is a positive development when considered from a workplace well-being perspective. Emotionally, they are likely not to

feel bad that they are taking care of the needs of other people, whilst their own family relations' care needs are neglected. All these issues, negative and positive, are central to the major concern of this study which is about the interconnections between workplace well-being and employee experiences.

The preceding discussion has established that migrants are increasingly becoming fundamental to aged care delivery in New Zealand (Callister et. al., 2014; McGregor, 2012; Ngocha-Chaderopa, 2013; North & Higgins; 1999; North, 2007;). Badker et al.'s (2009) study identified a number of shortfalls that has affected the quality of care delivery that was provided, including insights into the exploitation of migrant carers by employment and visa processing agencies, as well as the aged care facilities. The same study found that some migrants worked as many as 160 hours a fortnight to pay back the loans extended to them by the agents that facilitated the migrants' entry into New Zealand. Badker et al.'s (2009) study findings resonate with observations that many migrant aged care workers,

> "…are working too hard, for too long and for too little, and have no public way in which they can air their concerns' (New Zealand Human Rights Commission, 2010, p.103).

Similarly, Lovelock & Martin's (2016) study which explored the experiences of migrant care workers in institutional care settings found that migrants experience racial stereotyping in the workplace. Although the study shared significant insights into the experiences of the migrant care workers, its effectiveness is limited by its focus on the experiences of only one ethnic group of carers: Filipinos working in Auckland and Wellington. This criticism can also be extended to the 2017 St Andrew's Village and The Salvation Army's Social Policy and Parliamentary Unit study which provided personal stories of migrant workers without necessarily tying the stories to the well-being concept. Most of the studies therefore provided anecdotal fleeting evidence of challenges migrants encounter without necessarily linking the challenges to the concept of well-being.

Whist the value of these studies cannot be underestimated, in the context of this study, their insights of the aged care sector and migrants' participation are not deep enough to enable a richer understanding of the nexus between well-being and work experiences. To map the nexus between workplace well-being and work experiences, this study therefore provides voice to these migrant carers.

Conclusion

In this chapter, the New Zealand aged care context was illuminated by situating it within the care deficit or care gap global phenomenon. This is because it is essentially the care gap, which has largely contributed to the increased deployment of migrants as care workers – a key focus of this well-being study. It was also noted that whilst the New Zealand increase in ageing population reflects success of medicine and improvements in the standard of living (Badkar et al., 2009), it is not without challenges. One of these is the growth in numbers of older people who tend to experience multiple morbidities. However, the increase in demand for aged care services has not been met with a matching rise in the number of people seeking to fill up aged care vacancies. The nature of residential aged care work, especially "the physically and emotionally demanding work, which is undervalued and low paid" (Kaine & Ravenswood, 2014, p.33) in conjunction with the associated 'low status stigma' (Manchha et al., 2021) are some of the significant barriers to the engagement of a robust, professional and sustainable aged care workforce. In response to the labour supply shortage, New Zealand, like other Western countries, has resorted to the employment of migrant care workers. From the perspective of the workplace well-being focus of this study, the chapter used Castle's (2000) classification of migrants to provide some insights into why migrants 'accommodate' such largely negative aged care job conditions which New Zealand-born able-bodied employees find untenable. Castle's (2000) classification of migrants suggests that the largely harsh conditions that influence people to migrate to other countries might be the reason some of the migrants took up care jobs in their new country of residence. The immigration visa was identified as presenting challenges to the tenuous residence of migrant carer workers, making them more vulnerable in their precarious jobs. The chapter set out the characteristics of ARC work in New Zealand. It provided an analysis of the New Zealand regulation and policy oversight of aged care services, as well as the legal environment in which migrant care workers operate**,** emphasising the existence of polices to protect all workers. At the same time, concerns were raised about the possibility of policy rhetoric not matching practice considering the few recorded challenges migrant care workers experience in the workplace. Finally, this chapter underlines the lack of research on the experiences of migrant workers, even though they are an important source of labour. Against this background, the following chapter discusses this study's research methodology.

Chapter 5 - Methodology

Introduction

In this chapter, the narrative voice shifts to the first person to capture the intertwined interactions between the participants and interviewer. I discuss the research design here, which encompasses the research paradigm and the philosophical underpinnings of this study. More specifically, I discuss how the critical feminist ontological and epistemological premises influenced the conduct of this study. This discussion is premised on the understanding that any research undertaking ought to consider the assumptions and values underpinning its application (D'Silva et al., 2016). In other words:

> "Adopting a particular paradigm is like viewing the world through a particular instrument such as a telescope, an X-ray machine, or an electron microscope. Each reveals certain aspects but is completely blind to others … each instrument produces a totally different and seemingly incompatible, representation..." (Mingers, 1997, p.9).

The brief self-reflection contained in this chapter is therefore necessary because identity influences how researchers perceive the world (D'Silva et al., 2016). Operating in line with the critical feminist theory principles, this research's desired goal is to influence change through reflection (Maguire, 1987) in the aged care sector in relation to workplace well-being of migrant care workers. This change or transformation can take place at many levels, including policy changes that may enhance aged care delivery practice or at an individual level when participants become more conscious about the role of the work environment in their well-being. The drive to gain in-depth insights into the participants' views about the intersections between well-being and work experiences seemed more in harmony with a qualitative research design method. In this respect, one significant commitment that undergirds critical feminist research outside the power of epistemology is the situatedness of the researcher (Ackerly & True, 2008). To this end, in discussing the interview method, I will show how the adoption of 'multiple positionalities' enabled me to create an interview protocol that encouraged the migrant care participants to provide rich and authentic descriptions of their work experiences in relation to their well-being. Finally, before concluding the chapter, I discuss credibility and trustworthiness of the study, including the data analysis process.

Research aims, research questions and objectives

Trends show that migrant participation is increasingly becoming critical to the sustainability of the aged care sector, not only in New Zealand, but also in many other, especially, industrialised Western countries (see for example, Spencer, Martin, Bourgeault & O'Shea, 2010; Badkar et al., 2009). As a result, there is exponential growth in studies investigating their participation in the aged care sector (e.g., Cangiano & Shutes, 2010; Hargreaves et al.,2019; Ho & Chiang, 2015; King-Dejardin, 2019; Spencer et al., 2012; Thornton, 2010; Lovelock & Martin, 2016). Most of the extant studies share the view that migrant workers from poor or developing countries secure jobs that are dangerous, dirty, and poorly paid compared to non-migrants (Hargreaves et al., 2019; Moyce & Schenker; 2018; Orrenius & Zavodny, 2009). However, despite abundant evidence showing a link between working conditions, employee well-being and organisational productivity (Bryson et al., 2017; Ravenswood, 2011; Markey et al., 2008), none of these studies specifically examines the interface between workplace well-being and migrant care workers' work experiences. In this respect, this study aims to:

1. Contribute to the migrant experiences and well-being theory.

2. Give a voice to a group of employees that has not been heard before.

3. Contribute to practice by suggesting ways to improve migrant care workers' working conditions.

These aims are constructed against the premise that the goal of science informed by critical feminist theory is to support the development of a more just society (Fontana, 2004). To this end, three research questions guide the achievement of these aims:

1. How does migrant identity impact migrant care workers' well-being?

2. How do work conditions affect migrant care workers' well-being?

3. How do workplace relationships affect migrant care workers' well-being?

These questions espouse the critical feminist paradigm's overarching concerns, which include seeking to analyse competing interests among groups and individuals, identifying those who either do or do not benefit in specific social arrangements (Kincheloe et al., 2011; Steinberg & Kincheloe, 2010). In this case, the concerns relate to migrant care workers that are doing precarious jobs in work environments that do not always prioritise their well-being (Fudge, 2012; Kalleberg, 2011; Strauss, 2016).

Therefore, this thesis effectively seeks to establish whether the perspectives of migrant care workers regarding their relationships with the various elements of their workplace environment reveal them as ‘winners’ and/or ‘losers’ in relation to their workplace well-being levels. Suffice to state, that at the time of interviewing and analysing data, to the best of my knowledge, no research in New Zealand had investigated the nexus between well-being and migrant care workers’ work experiences. I here contend that this is a deep lacuna in extant literature. This research therefore opens a window into the experiences of migrant care workers and voices that have hitherto been unheard in New Zealand.

Research design

Research design is “…the complete strategy of attack on the central research problem" (Leedy & Ormrod, 2001, p. 91), or a conceptual blueprint of the steps involved in addressing the research problem (Bloomfield & Fisher, 2019). It connects the plan of action with the underpinning assumptions and frameworks in the methodology, methods and data collection techniques (Cooper & Schindler, 2003; Miller & Cameron, 2011). A survey of the literature however, points to the existence of some conflicting positions about the steps that constitute the research process. For example, Saunders et al., (2009) argue that there are five layers of the research process (Figure 3.1) that must be peeled away before deciding on the data collection method. They depict this in the form of a ‘research onion’ (Saunders et al., 2009, p. 108) which demonstrates the major steps in the research process.

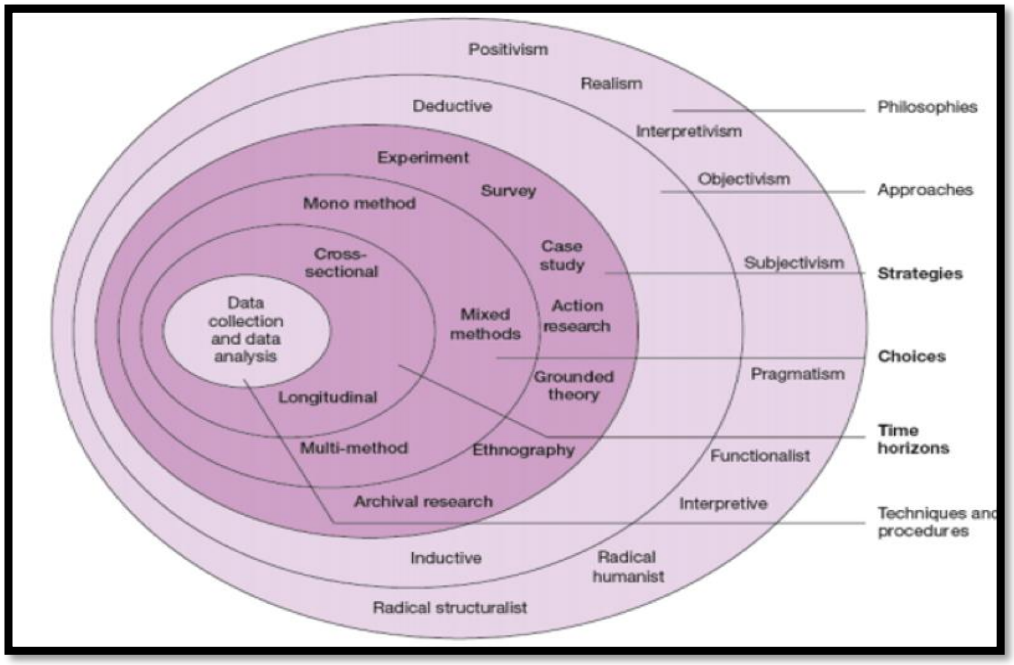


Figure 5.5 Research onion
Source: Saunders et al., 2009, p. 108.

This research onion was useful in this study because it illustrates that research is “a methodical approach to address the research question (Kothari, 2004; Saunders & Lewis, 2012). It was a useful reminder that the effective address of a study’s objectives was preceded by a systematic application of a meticulously designed process in which appropriate epistemology, theory and methodology ground the selection of suitable data collection methods. However, some elements of this onion disqualified it from being applied in its fullness to influence this thesis’ methodology. For example, the research onion does not distinguish between, ‘ontology’ and ‘epistemology’ nor does it clearly differentiate philosophies from theories.

It is in this context that Crotty (1998) argued that “the terminology used in research literature is confusing, with epistemologies, theoretical perspectives, methodologies and methods thrown together in grab-bag style as if they were all comparable terms” (p.3). This is regardless of the view that these terms represent distinct stages in the research design process. Ironically, the explanation given by Crotty about these hierarchical levels does not entirely provide clarity regarding the research process elements and their placing in the research process. For example, Crotty’s (1998) view is that the first step in the research process is determined by a researcher’s beliefs about the nature of knowledge. Crotty identifies these stances as “objectivism” or “subjectivism”. Therefore, in Crotty’s view, epistemological considerations start off the research process followed by the theoretical perspective, methodology and methods. Despite conflating epistemology and ontology, Crotty’s framework, like Saunders et al.’s (2009) Research Onion, served as a reminder that ideas underlying any study must fit together within the different layers, ensuring consistency between them. This preceding discussion therefore logically leads to the concept of research paradigms.

Research paradigms

Notwithstanding these multiple and sometimes conflicting perspectives regarding the place of different aspects of the research design in the research process, it is widely agreed that one of the most important research design aspects is the “research paradigm” (Creswell, 2007; Guba & Lincoln, 1994). It is argued that to create a robust research design it is important to be guided by a paradigm that is in harmony with one’s “beliefs about the nature of reality” (Mills et al., 2006, p.2). In this section, I provide a brief general discussion of research paradigms before focusing on the merits of the critical feminist paradigm that shaped the conduct of this present study. Research paradigms refer to an “entire constellation of beliefs, values, techniques … shared by the members of a given community” (Kuhn, 1970, p.175) and therefore reflect the

researcher's fundamental beliefs "…or worldview that guides the investigator in choices of method, ontology and epistemology" (Guba & Lincoln, 1994, p.105). A paradigm is generally cast as a worldview that represents "…ways of experiencing and thinking about the world…" (Morgan, 2007, p.49).

Regarding what constitutes a paradigm, some studies identify four dimensions: ontology, epistemology, methodology and methods (Scotland, 2012), while others identify three philosophically distinct categories. These are positivism, interpretivism, and critical postmodernism (Gephart,1999). However, Guba & Lincoln (1994) use diffferent terminologies of 'positivist', 'post-positivist' and 'postmodernist enquiry'. Guba & Lincoln (1994) also place 'postmodernism' and 'post-structuralism' within the 'critical theory' paradigm. Evidently therefore, the confusion of definitions is not only restricted to the research design concept but extends to the term 'paradigm.' Definitions of paradigm provided by research leaders such as Guba & Lincoln (2005); Creswell, (2009); Creswell & Miller, (2000); and many others, betray a lack of consensus about the definition of a paradigm. At the same time, a synthesis of the different definitions of paradigm suggests that a paradigm is a philosophy or theoretical perspective that guides the researcher's approach to the collection, analysis and interpretation of data. Effectively, the paradigm that a researcher builds in their mind creates the lens through which the researcher sees the world. Regarding the elements of, and their placing in the research process, in this present study, ontology is placed first as captured in Figure 5.2. *Author's conceptualisation of the research design process*

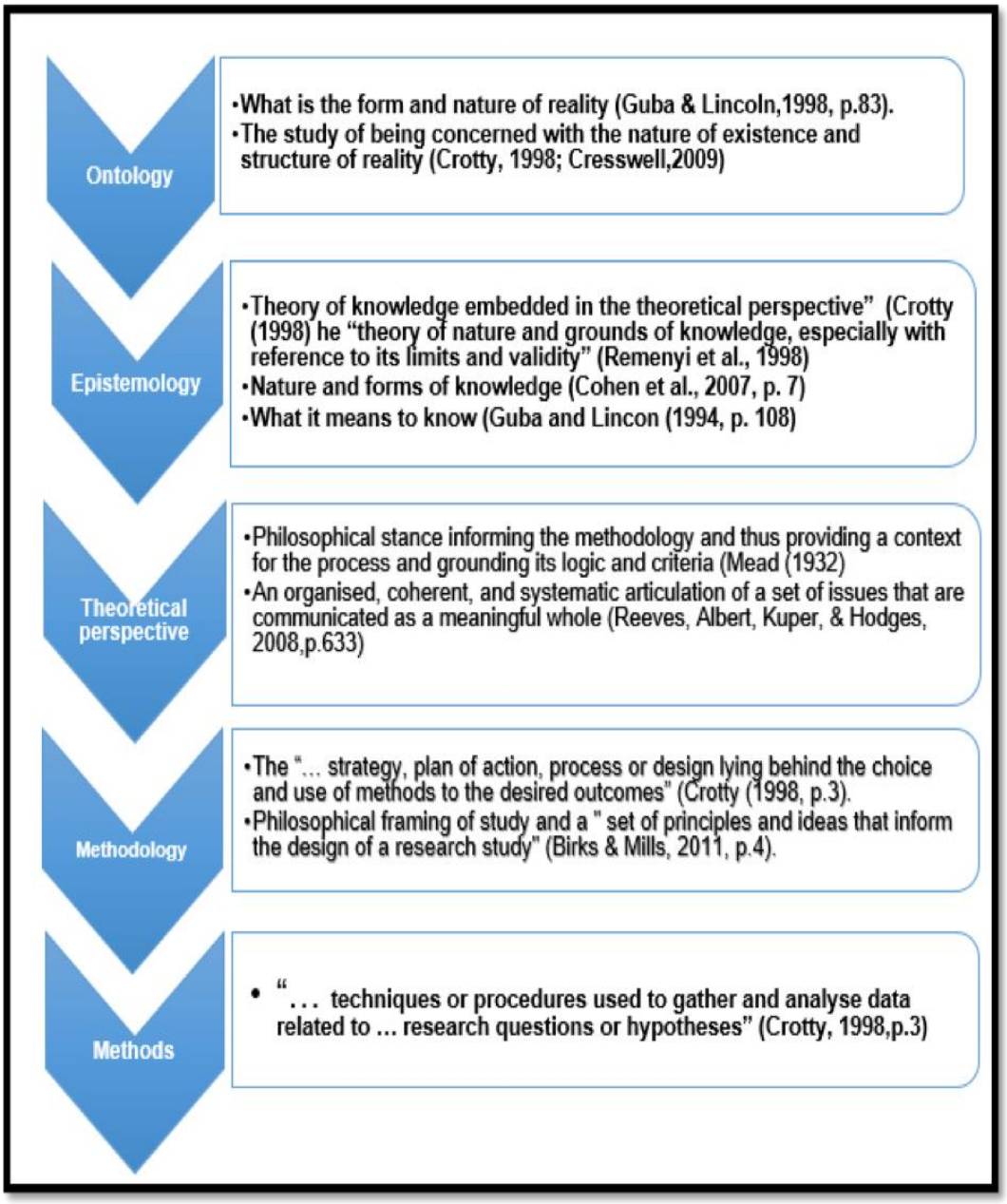


Figure 5.6 Author's conceptualisation of the research design process
Source: Adapted from Birks & Mills, 2011; Creswell, 2009; Crotty, 1998; Guba & Lincoln, 1989; 1990; 1994; 2005; Grix, 2002; Saunders et al., 2009.

Several studies consider ontology as the commencement point for all research, followed immediately by epistemology, methodology and methods (Creswell, 2009). The intricate relationship between ontology and epistemology and their key role in the research process are captured in the form of an analogy of house "footings" that "form the foundations of the whole edifice" (Grix, 2004, p.59). This role of the two concepts in research might be one of the reasons Crotty (1998) conflated ontology with epistemology, arguing that the two are inseparable because "… to talk about the construction of meaning [epistemology] is to talk of the construction of a meaningful

reality [ontology]" (1998, p.10). This resonates with King & Horrocks' argument that "ontological and epistemological issues often arise together" (2010, p.8).

Although the two terms are closely related, they still need to be separated. Furlong & Marsh, for example, argue that "one's ontological position affects, but far from determines, one's epistemological position" (2010, p.18, see also Hay, 2006). In this regard, the two most referenced ontological paradigms are positivism and interpretivism. The third one – pragmatism – intersects these two (Shannon-Baker, 2016; Morgan, 2014).

Positivists believe that there is "an apprehendable reality that exists, driven by immutable natural laws and mechanisms" (Guba & Lincoln 1994, p.109). Because of this stance on reality, a positivist epistemology is "dualist and objectivist" wherein it is presumed that there is a clear-cut separation between the ''subject'' and ''object'' (Guba & Lincoln, 1994, p.110). Sayer identifies a set of parallel dualisms that grounds this separation, for example, ''reason–emotion'', ''mind–body'', ''fact–opinion'' and ''thought–action'' … in which left-hand terms are unequivocally superior to right-hand ones" (1992, p.45). Objectivism postulates that "truth and meaning reside in objects independent of any consciousness" (Crotty, 1998, p.42). Since research is time and context-free, research findings can be generalised to a larger relevant population. Logically, the methodology of positivists involves experimentation and manipulation of variables (Guba & Lincoln, 1994; Kivunja & Kuyini, 2017). A variation of the positivist is post-positivism, which "straddles both the positivist and interpretivist paradigms" (Grix, 2004, p.86). The post-positivist paradigm acknowledges the possibility of the researcher's own beliefs and values that affect what is being observed. Although it abandons the positivist idea of dualism, the post-positivist modified dualist/objectivist epistemology still maintains objectivity as the "regulatory ideal" (Guba & Lincoln, 1994).

In marked contrast to positivism's "naive realism of a single objective external reality" (Ponterotto, 2005, p.129), is the interpretivist paradigm and often called the "constructivist paradigm" (Kivunja & Kuyini, 2017). This is primarily because it treats reality as a social construction which does not need to be scientifically verified or mathematically proven (Berger & Luckmann, 1966; Bogdan & Biklen, 1998; Lincoln & Guba, 2000). The interpretivist paradigm assumes relativist ontology, a transactional subjectivist epistemology, and a naturalist methodology (Guba & Lincoln, 1994, p.111). Relativism is the view that reality is subjective and individually constructed, which implies that there are "as many realities that are locally and historically specific as individuals" (Guba & Lincoln, 1994, p.110). This means that "the world does not exist

independently of our knowledge of it" (Grix, 2004, p.83). This implies that the same phenomenon can be interpreted differently by different people (Crotty, 1998). Since the social world can only be understood from the standpoint of the individuals being investigated, it is extremely difficult to separate an objective reality from the research participant who experiences, processes and labels that reality (Ponterotto, 2005; Sciarra,1999). As a result, one of the most distinguishing characteristics of the interpretivist paradigm is the centrality of the interaction between the researcher and the researched, or the object of investigation (Hammersley, 2013). Interpretivists therefore encourage interaction and cooperation between the two (Cohen et al., 2007; Holliday, 2007). Methodologically**,** interpretivism, promotes the value of qualitative data in pursuit of knowledge (Thanh & Thanh, 2015). This is primarily because the paradigm is concerned with the uniqueness of a particular situation and contextual depth (Creswell, 2007). Therefore, the most used methods of collecting information are interviews, discourse analysis, and textual analysis (Carr & Kemmis, 2003). Interpretivists are therefore interested in the quality or the richness of the collected data, rather than its quantity (Leitch et al., 2010; Morrow, 2005; Welch & Piekkari, 2017).

The preceding discussion identified paradigms that are inherently juxtaposed in the way they view reality and how or whether they can be established. The paradigms present two contrasting researcher positions: either the researcher accepts or does not accept that facts exist independently of the human mind (Pölzler & Wright, 2020; Scott, 2007). This is because these philosophies are not mere theoretical beliefs but capture how the world operates (Wiggins, 2011, p.45). The pragmatic paradigm evades these "paradigm wars" (Giddings, 2006; Giddings & Grant, 2007; Morgan, 2014) by arguing that in carrying out research, a single viewpoint is incapable of capturing the participants' multiple realities. Pursuant to this position, pragmatism encourages the adoption of a "what works" (Tashakkori & Teddlie, 2003, p.713) methodology that permits the researcher to integrate diverse research approaches and research strategies within the same study. Oakley (1999) therefore advocates moving beyond and closing the "paradigm war" because it stops researchers from using the most appropriate method for the job or producing the best research possible.

Researcher reflexivity

As has already been established previously, my ontological perspective is that the world of social interaction does not exist autonomously of what I as the researcher perceive it to be (Scotland, 2012). In this respect, Patton argued that the researcher is the "instrument of data collection and analysis" in qualitative inquiry (2002, p.14). As a

result, understanding the researcher's world view and experiences is important in qualitative research. In this regard, some previous studies have observed that researchers tend to encourage their study participants to reveal who they are without necessarily doing the same (Behar, 1996). This criticism is even more significant when it is considered from the critical feminist ontology and epistemology of this study which acknowledges the roles of the researcher's worldview and issues of power between the researcher and study participants (Guba & Lincoln, 2008; Holgate et al., 2006; McLaren & Kincheloe, 2008). As Harding & Norberg (2005) noted, research processes "produce and reproduce power differences" regarding the ways that can be used to know the world. A critical feminist research ethic therefore requires the researcher to be aware of power dynamics between the researcher and the researched to avoid marginalising the study participants (Ackerly & True, 2008).

It is in this context that before discussing the critical feminist ontological and epistemological premises of this present study, including its methodology and methods, I start by locating myself as both a person and researcher. This is because one's values, assumptions and prejudices, as well as position within the social world, influences the way in which one sees the world (Hand, 2003; Koch & Harrington, 1998; Lambert et al., 2010; Temple & Young, 2004). This is the domain of "reflexivity": a "deconstructive exercise for locating the intersections of author, other, text, and world and for penetrating the representational exercise itself" (Macbeth, 2001, p.35).

Although the concept of researcher reflexivity is important for many forms of research, it assumes even greater significance when considered in a qualitative research context. This is because ordinarily, in qualitative research, the researcher as the primary instrument of data collection and analysis cannot be separated from the data collection process, as well as the resultant findings and conclusions (Berger, 2015; Horsburgh, 2003; Russell & Kelly, 2002). Researcher characteristics such as race, class, gender, nationality, sexual orientation, age, migrant status and personal experience can influence access to the "field" because respondents tend to feel comfortable sharing their experiences with someone, they think is going to be sensitive to their situation (Bradbury-Jones, 2007; De Tona, 2006; Padgett, 2012). In this case, my previous role as a migrant care worker, as well as my female gender, accorded me not only the opportunity to grow a strong network of mostly female migrant care givers that was valuable when I started looking for participants for this study, but it also influenced the details the participants were willing to share with me about their personal and work experiences.

A detailed discussion of the practical influence of diverse aspects of my identity to this study's methods is provided later in the section *Researcher positionality and interviewing approaches*. It suffices at this stage to note, that when I reflect on the origin of this PhD thesis, it is easy to see how my identity and experiences of being an immigrant care worker in New Zealand were the major stimuli. I am a black Zimbabwean female who migrated to New Zealand in 2007 and have since attained New Zealand citizenship. I arrived in New Zealand having already completed a Bachelor of Science Honours Degree in Human Resource Management and a master's degree in Business Administration. I had also worked as a Human Resource Officer for one of the biggest public sector companies in Zimbabwe.

A rude awakening for me was the realisation that my qualifications were not as competitive in the New Zealand job market as they were in my home country. They could not help me secure a job like the one I had in Zimbabwe. The most promising job opportunities were in the aged care sector. This is consistent with previous research that noted that migrants and refugees tend to experience higher levels of unemployment and underemployment and poorer remuneration (Colic-Peisker & Tilbury, 2006, 2007; Liebig, 2007). In my aged care role, I discovered the increasing role played by migrants in taking care of the elderly in the New Zealand aged care sector. At the same time, I decided to embark on a Postgraduate Diploma in Management and a Master of Commerce with the University of Otago. The aged care sector was therefore a natural choice of academic research. In my master's degree dissertation, I explored the managers' perceptions of the challenges associated with migrant carers' employment in the New Zealand aged care sector. This topic of well-being and migrant care workers was appealing because it is firmly located in my lived experience as a migrant, wife and working mother, reconciling the sometime conflicting duties of being a mother, an employee, and a student.

In my new aged care worker role, I learnt that many of my other migrant carer colleagues had never considered aged care jobs as a potential source of livelihood until they arrived in New Zealand. I noticed that most of the migrant care workers were literally stunned by the realities of the care job, such as low pay and the hard nature of aged care job tasks (Hussein et al., 2011; Hussein & Manthorpe, 2005). At the same time, despite these hardships, many of my migrant care worker colleagues found a lot of fulfilment in taking care of another human being. Because of my experiences and observation as a migrant care worker, in conducting my research, I therefore sought a paradigm that overtly articulated issues of inclusion and marginalisation, empowerment and disempowerment, as well as emancipation of the 'voiceless' and less powerful.

My experiences therefore did not only influence the choice of my research topic, but also this study's critical feminist paradigm. In search for a suitable paradigm to shape my investigation, I wanted one that accepted the position that as a researcher, I am value laden, immersed, and active in my study (Grimes, 1992). I wanted a paradigm that had the capacity to respect my first-hand deeper insight into aged care work practices such as changing diapers, giving showers, dressing, making beds, feeding aged patients, and relating to patients, their relatives, co-workers and managers. I did not want a paradigm that would simplistically treat all these – my authentic migrant care worker experiences – as sources of researcher bias.

I sympathise with the positivists' argument that the researcher should not be personally involved in a study and that an "outsider" is better able to observe and interpret behaviours of interest to a study (Lincoln & Guba 1985). However, I do not believe that a strict outsider approach to research would have worked with immigrants. Some studies argue that generally immigrants do not trust outside researchers (Fisher & Ragsdale, 2006; Greene, 2014). It is also argued that the outsider researcher is largely unable to correctly interpret certain behaviours and may also miss significant details about migrants because those details do not signify issues of importance to the outsider (Greene, 2014; Fisher & Ragsdale, 2006; Renert et al., 2013; Unluer, 2012). This explains why I desired a paradigm whose ontological and epistemological assumption would agree that it is possible to know the interests of others without necessarily articulating a personally privileged account. A fitting paradigm therefore was one that would treat the relationship between the knower and the subject as one of involvement and interaction and not detachment (Yilmaz, 2013). Understandably, the positivist's "dualist and objectivist" epistemological assumptions that the researcher and the researched are autonomous entities in search for absolute truth (Guba & Lincoln, 1994) and that neither of them can exert influence on the other, were not appealing to the issues at hand nor to my assumptions about reality and how we come to know about it.

I was also keen for a paradigm that would enable me to understand issues of well-being at an organisational and individual level situated against the backdrop of a larger social, political and economic milieu. Probably a mirror analogy will suffice in succinctly demonstrating my argument here. When we look at the mirror, we see our image. However, our image is not only the object being reflected. Our macro background environment is also reflected in the mirror. In most cases, the quality of the environment affects the quality of our mirror images. One mirror image can therefore look different depending on, for example, the presence or absence of background light.

In search for an appropriate paradigm, I was therefore interested in one that would not only enable me to interrogate the issues of migrant care workers' experiences and well-being at an organisational unit level (the immediate and salient object in the mirror), but to situate the reactions of the migrants to aspects of the workplace setting within a larger macro socio-political and economic environment (the background macro environment of the mirror object.

The concept of dialectical materialism, which forms the basis of the concept of 'critical,' explains this point further. Dialectical materialism emphasises that an analysis of societies and ways of life demands a more comprehensive approach, one that does not view society and social institutions merely as a singular unit of analysis, but rather as ones that are replete with history (Harvey, 1996). By macro environment, I am referring here to, for example, the issues discussed in Chapters One and Two about the global gendered, feminisation of care, and the neoliberal ideology influencing commodification of care which have largely contributed to undesirable working conditions in the care sector (Fine & Davidson, 2018; Hoppania & Vaittinen, 2015; King & Meagher, 2009b; Lewis, 1992; McCarthy & Prudham, 2004; Ungerson, 2005; Ungerson & Yeandle, 2007b; Ravenswood, 2011).

Finally, by macro environment, I also refer to the "pull" and "push" factors (Castle, 2000; Hugo, 2009b; Jakubowicz, 2010) that influenced the migrants' journey to New Zealand. It is argued for example, that the migration and migrant status elements are results of the interplay of various forces at both ends of the migratory axis (Likupe, 2011). Studies on the migration push-pull factors reflect that most people leave their home countries to evade persecution or political, economic, social and religious hardships (Baum, 2012) or to get access to social protection schemes, quality education, employment, health care and amenities (Willekens et al., 2016). It is therefore argued that "the idea of individual migrants who make free choices...is so far from reality that it has little explanatory value" (Castles & Miller, 2003, p.25). These factors provide some context to the migrants' "choice" to care for the aged as a source of livelihood and the implications for their workplace well-being. It is against this backdrop, that the critical paradigm emerged as naturally fitting to shape the investigation of workplace well-being and the migrant care workers' experience, as is explained in the following section.

The critical feminist philosophical underpinnings of the thesis

In qualitative research, theory provides an overall orienting lens for the study of issues of marginalised groups and provides a call for action or change (Creswell, 2008).

Chapters One and Two have already established that the context of this well-being thesis is the aged care employment sector that is generally stigmatised for its poor working conditions as well as being highly feminised and undervalued (Hussein & Manthorpe, 2005; International Labor Office [ILO], 2013b; Palmer & Eveline, 2012; Vanek et al., 2014). Aguilar-Cunill (2017) argued that work in a feminised environment inevitably makes gender a significant concern, especially regarding how men and women are perceived as workers. In the case of care work, gender also determines recruitment of workers and the construction of the ideal caregiver; or in the recruitment processes (Aguilar-Cunill, 2017). Generally, society use gender stereotypes and gender differences in their representations of a woman or a man (Williams & Best, 1990; Golombok et al., 1994). There are many stereotypes related to jobs and professional categories (Koch et al., 2015). Previous studies have observed that most stereotypical gender beliefs can be classified into two categories: communal and agentic (Koch et al., 2015; Eagly & Steffen, 1984). Communal attributes relate to concern for others, such as being helpful, kind, nurturing, emotionally expressive and affectionate (Eagly & Karau, 2002). These attributes are generally associated with women. On the other hand, agentic qualities that reflect a predisposition to be assertive, controlling, dominant, ambitious, independent and confident are more generally associated with males (Eagly & Karau, 2002). Stereotypes can therefore be very restrictive in that they prescribe and describe how and who men and women should be (Eagly, 1987).

It is in this context that this thesis was informed by a critical feminist ontological and epistemological perspective. Critical theory “seeks ... to liberate human beings from the circumstances that enslave them” (Horkheimer, 1982, p.244). In the same vein, Poster (1989) argues that “critical theory springs from an assumption that we live amid a world of pain, that much can be done to alleviate that pain, and that theory has a critical role to play in that process” (p.3). Critical theory is also concerned about legitimacy and equality, issues of repression, voice, ideology, power, representation, inclusion and interests (Cohen et al., 2007). One of its major focus areas is ensuring the representation of diverse and under-represented views (Gortner, 1993). This thesis investigates a group, specifically ARC migrant employees that may be disadvantaged in their work conditions (Adebayo et al., 2020; Behtoui et al., 2020; Munkejord, 2017). As was discussed in Chapters One and Two, the gender of the workers is a significant dimension of these disadvantaged aged care workers. For example, with reference to migrant women workers, it is argued that as members of a racial, religious or ethnic minority, they usually suffer the double jeopardy of both sex and other forms of inequality (Martin, 2003). In this way, critical theory resonates with feminist

epistemological approaches whose central focus is questioning the complex relationship between power, gender and sexuality (Hester & Donovan, 2009).

Feminism has been defined as “a movement to end sexism, sexist exploitation, and oppression” (hooks, 2000, p.1). Originally feminism was largely about the experiences, lives and struggles of women and others who are disadvantaged (Donovan, 2012; Harding, 2007). With time however, feminism became less about gender and more about the interrogation and exposure of structures in society that perpetuate the oppression and suffering of the marginalised, regardless of gender (Harding, 2008; Ropers-Huilman, 2002, 2003; Tickner, 2005, 2006).

Feminism is therefore not a static notion; rather it evolves with and is shaped by the experiences that shape the adherents’ worldviews (Harding, 2008; hooks, 2000; Nicholson et al., 2011; Ravenswood, 2011; Ropers-Huilman, 2002). In this study, critical feminist ontological and epistemological perspectives facilitate the capturing of the voices and experiences of the often-marginalised migrant care workers. The feminist theoretical framework therefore presents opportunities to examine how care has been feminised, but also enables a critical analysis of the gender discourse of men who participate in the paid work of care giving. As was argued in the Literature Review Chapter Three, men that cross the gender dichotomy by becoming care workers are censured by society for stepping out and are “marked”, seen as deviant and separate from the mainstream (Baxter, 2011; Ku, 2011; McDowell, 2015). Such men cannot pass as “real men” (Nentwich & Kelan, 2007) as society looks down upon them for failing to live up to the ideals of “hegemonic masculinity” (Buschmeyer & Lengersdorf, 2016; Messerschmidt, 2018). It is therefore argued that the men who work in female-dominated jobs, endure negative work experiences regarding both “working conditions and social prestige” (Hussein & Christensen, 2017, p.21).

The choice of critical feminist theory is also based on its treatment of “organizations as social historical creations accomplished in conditions of struggle and domination, a domination that often hides and suppresses meaningful conflict” (Deetz, 1996, p.202). In discussing the well-being-workplace nexus, this thesis places emphasis upon the role of the context in the way knowledge and social relationships are constructed (Alvesson & Deetz, 2000). This suggests that the way migrant care workers perceive their well-being is socially, economically and historically constituted. Critical theory therefore argues that “much behaviour is the outcome of particular illegitimate, dominatory and repressive factors” and that they are “illegitimate in the sense that they do not operate in the general interest...” (Cohen et al., 2011, p.31). The authors emphasise that interests are socially constructed which explains why those with power

and more knowledge tend to define the world for others. The more powerful members of society influence not only their own experiences and realities but the experiences and realities of those with less power (Kincheloe & McLaren, 2008). The criticality of "critical theory" is therefore attributed to the fact that once its practitioners identify the structure or processes, which have generated the events of social reality; they seek to transform the status quo (Bhaskar, 1997).

With reference to the critical theory's goal of transformation, the literature review section of this present thesis has already established that Human Resources and/or management practices of aged care facilities can affect changes that have positive impacts on the workplace that influence employee well-being (see Boxall & Macky, 2014; Guest, 2017). The transformation of the migrant care workers, be it in a subtle intellectual, psychological, physical, emotional or any other form, is critical to this thesis. It must be noted that the outcome is not guaranteed (Lather, 1986). If this were to happen, it would still not disqualify this thesis from the critical paradigm domain because it is the possibility of change, rather than the promise of it, which defines critical science (Fontana, 2004). This partly explains why understanding the well-being of individuals in the work setting, where they spend most of their adult life, is an emancipating endeavour to pursue (De Simone, 2014).

The attraction of the critical feminist paradigm is also located both in its "transformative emancipatory ontology" which subscribes to the view of the existence of multiple realities that are politically, socio-culturally, historically, and economically situated (Mertens, 2009). Critical research's epistemological concern with issues of equality and inclusion leads to the adoption of an interpretive methodology that provides opportunities to research participants to "document their own experiences in their own terms" (Tickner, 2005, p.19). This approach acknowledges that in exploring the perspectives of migrant care workers about the well-being-workplace experiences nexus, different migrants will assess that nexus using their individual lenses, for example. At the same time, as the researcher, I will also bring my own values to the research setting. This intertwined interaction between the investigator and the investigated results in the findings being "value mediated" (Guba & Lincoln, 1994, p.110). This transactional and subjectivist epistemology of critical feminist theory therefore acknowledges that "the researcher cannot simply disappear from the text" (Jacoby 2006, p.162). The interaction between researcher and research subject is therefore necessary in the gathering of empirical material (Crotty, 2003; Guba & Lincoln, 1994). This makes this paradigm particularly attractive because its tenets do

not see any fundamental friction between my former role as a migrant care worker and a PhD student studying other migrants.

My migrant identify was therefore an enabler of a richer, nuanced, and multileveled understanding of the responses of the migrant care workers and not a source of bias or hindrance to the goal of understanding the way workplace experiences and well-being are related. Mertens (2005) reinforces this view by arguing that the interaction between the researchers and the participants is necessary, requiring trust to enable accurate and fair representation of the researched. My multirole as a female, mother, wife, lecturer, and former migrant care worker, influenced what I heard and how I interpreted it in relation to the study objectives.

Critical dialogic/dialectical methodology

In discussing the methodology of this thesis, it is noted that the use of the term methodology and other terms such as paradigm and method is “incredibly messy in the literature” (McGregor & Murnane, 2010, p.420). Methodology refers to the application of theory and epistemology in a specific study (Steinmetz, 2020; Wickramasinghe, 2019). As a result, it is more philosophically value laden compared to the method concept (King, 1994) representing the ways in which issues are investigated and interpreted (Fontana, 2004).

Methodologically, critical theory is conceptualised as emancipatory and usually employs the basic research instruments of ideological critique and action research (Habermas, 1976; Cohen et al., 2000, 2007). Hussain et al. (2013) posit that ideological critique involves analysing the values, practices and interests of the dominant groups in relation to the disempowered (Dieronitou, 2014). Apart from action research and ideology critique, the other critical methodologies used by critical theorists are discourse analysis and critical ethnography (Carr & Kemmis, 2003). The methodology of this thesis, however, is derived from Guba and Lincoln’s (1994) description of critical theory methodology as dialogic or dialectical, as represented in Table 5.1

Table 5.9 Basic beliefs of different paradigms

Item	Positivism	Post-positivism	Critical Theory.	Constructivism/ Interpretivism
Ontology	naïve realism – "real" reality but apprehendable	critical realism – "real" reality but only imperfectly and probabilistically apprehendable	historical realism –virtual reality shaped by social, political, cultural, economic, ethnic, and gendered values; crystallised over time	relativism – local and specific constructed realities
Epistemology	dualist/objectivist; findings true	modified dualist/objectivist; critical tradition/community; findings probably true	transactional/subjectivism; value-mediated findings	transactional/ subjectivist; created findings
Methodology	experimental/ manipulative verification of hypotheses; chiefly quantitative methods	modified experimental/ manipulative; critical multiplism; falsification of hypothesis; may include qualitative methods	dialogic/dialectical	hermeneutical/ dialectical

Source: Guba &Lincoln, 1994, p.109.

The critical paradigm's emphasis on inclusion of the marginalised groups in society is a logical fit with concerns about how societies take care of their elderly residents who can no longer provide self-care and are also normally marginalised. Research has found that old age leads marginalisation and exclusion by members of society (D'cruz & Banerjee, 2020; Kaushik, 2020). The critical paradigm is therefore appropriate to the examination and exposure of contradictory values reflected in different care regimes and individual aged care facility management practices in relation to the well-being of migrant care workers. Among other concerns, it enables an examination of the way working conditions, such as pay levels and immigration visa issues, affect the migrant care workers' well-being.

Methods: In-depth interviewing technique

It is argued that critical researchers must deploy data collection methods that suit their critical enquiry (Mertens, 2009). The dialogic methodology influenced the use of interviews: “The most prominent data collection tool in qualitative research” (Punch, 2009, p.144). The interview technique has the advantage of flexibility and suits inquiries that are not motivated to unearth objective reality, as is the case with the scientific or positivist model but are more concerned about understanding the meaning people attach to their experiences of their lived world (Kvale, 1996; Rubin & Rubin, 2005). In this respect, interviews are described as conversation (Denzin & Lincoln, 1998; Kvale, 1996) and social encounters in which the interviews were “not merely a neutral conduit or source of bias but rather the productive site of reportable knowledge itself” (Holstein & Gubrium, 1995, p.3, see also Holstein & Gubrium, 2020; Rapley, 2001).

The use of semi-structured interview questions enabled the participants to provide rich open-ended responses. One of the advantages of open-ended questions is that they enable the researcher to see the world from the perspective of the researched (Patton, 2002). The semi-structured questions also gave the participants freedom to respond without necessarily limiting themselves to the specific issue asked. They were able to bring other topics into the discussion, which ultimately made the research process a cooperative process in terms of knowledge production (Fedyuk & Zentai, 2018).

Sampling strategy

This thesis started in Dunedin, in the South Island, where my PhD journey commenced at the University of Otago before transferring to Auckland University of Technology (AUT). Effectively this created two sampling time frames for me. By the time I transferred to AUT, the University of Otago Ethics Committee had already approved my Research Ethics application in November 2016, and I had already started searching for, and interviewing participants. Twelve participants were interviewed when I was enrolled at the University of Otago. After transferring, I sought ethics approval from the Auckland University of Technology Ethics Committee (AUTEC) which was granted in December 2018. I then resumed the process of searching for and interviewing more participants. I interviewed eleven more participants, which resulted in a total of 23 participants.

Recruiting participants proved less difficult than I had anticipated. My task as the researcher was to identify the key informants with whom initial contact was to be made in line with Patton’s (1990) view that snowball sampling “begins by asking well-situated

people: “Who knows a lot about? Who should I talk to?” (p.176). A key qualitative feature is that the researcher's intent is not to generalize from the sample to a population, but to explain, describe, and interpret (Maxwell, 2013) this phenomenon. As a result, sampling is not a matter of representative opinions, but a matter of information richness. Patton (2015) explained that purposeful sampling involves selecting information rich cases. As a qualitative study unconfined by the requirements for generalisability of findings, purposive sampling and snowball sampling were used to recruit participants (Emerson, 2015). Initially, I approached some colleagues I had previously worked with as a care worker to determine if they were interested in being part of the study. I also asked them to help identify other colleagues that could take part in the study. The participants therefore referred the researcher to others who were able to potentially contribute to or participate in the study. The participants also passed on my details to a third party and those who were interested in taking part in the study volunteered by contacting me. I was overwhelmed by the enthusiastic responses that were generated through this “snowball sampling or chain referral sampling” (Penrod et al., 2003).

In my roles as student and lecturer I met many immigrant students who were working as care workers. I approached these students to pass on my details to any third party in their respective workplaces that were interested in taking part in the study. I was therefore able to interview people working in Dunedin and some North Island cities such as Auckland, Rotorua, and Hamilton. I informed all the potential interviewees about the study’s aims and what their participation entailed, including its voluntary nature and guaranteed anonymity. They were also informed that their views were needed for academic purposes only.

Sample size

Regarding sample size, it is generally agreed that the idea of a sufficient sample size varies from study to study (Adler & Adler, 2012). Merriam (2009) noted that the sample size in qualitative studies depends on the research questions, the data collected, the data analysis, and the availability of resources. Smith et al (2009) argued that as the goal of qualitative research is quality and not quantity of collected information, a guideline of 3-16 participants for a single study was suggested (Smith et al., 2009). In this respect, Guest et al., (2006) recommended a sample size of 12, whilst Hennink et al. (2017) believe a sample size of nine participants.

Warren suggests that the norm in terms of the minimum number of interviews is in the range of 20–30 in order to ‘have a non-ethnographic interview study published’ (2002, p. 99). Although Gerson & Horrowitz (2002) have argued that fewer than 60 interviews

are unlikely to generate reasonable and convincing results, to the specific question of how many qualitative interviews are enough, Merriam wrote, “there is no answer” (2009, p.80). In agreement, Emmel (2013) and Morse (2000) cautioned against rigid reliance on any suggested sizes and recommended that researchers account for the scope, the topic, the quality of data, the design, and the use of shadowed data (i.e., participants' reports about others). An important consideration about sample size is whether the sample accords rigour to the study, “not in terms of size but in terms of its ability to supply all the information needed for comprehensive analysis” (Yardely, 2000, p.221). The sample should therefore not be so small that it makes it difficult to achieve data saturation, theoretical saturation, and informational redundancy (Gerson & Horrowitz, 2002).

Many studies use the concept of “saturation” (Glaser & Strauss, Saunders et al., 2018) to determine the sample size. Saturation, described as the ‘the gold standard’ for determining the end point of qualitative analyses (Guest et al., 2006; Roy et al. 2015) refers to “the point at which no new information or themes are observed in the data” (Guest et al., 2006, p.59). At the same time, it has been argued that there is no magic number to ensure that one will achieve saturation and that determining saturation should not be about numbers but about understanding that the unit of analysis is the concept, not the case (Corbin and Strauss 1990). Morse et al. (2002) uses the term ‘sampling adequacy’ to refer to saturation arguing that it is achieved when “sufficient data to account for all aspects of the phenomenon have been obtained” (p. 12). Morse (1995) argues that it is at this point that researcher stop the data collection process.

In this study, the concept of ‘theoretical saturation’ (Becker (1970, p.52) was key in determining the sample size. The units of analysis in this study are well-being and workplace experiences. In this study, the point of saturation was reached when I discovered that the primary data derived from the participants extensively mirrored several well-being and workplace concepts that had been examined in the literature review sections of the study. As I approached the 23rd interview, I concluded that I had interviewed sufficient participants to enable useful interpretations about the intersections between well-being and workplace experiences in a context of migrant care workers. For example, participants discussed work experiences that corroborated the conceptualisation of workplace well-being as an amalgam of physical, social, psychological/emotional and spiritual well-being. These categories are evident in extant literature that examines the well-being-workplace nexus (for example Baptiste, 2008; The Chartered Institute of Personnel Management, 2008, p.11; World Health Organisation, 2009, p.889; Warr, 2002, p.198). This argument aligns well with

Charmaz's (2006) view that, "[Y]ou conduct theoretical sampling to develop the properties of your category (ies) until no new properties emerge" (p. 96).

For me therefore, saturation was not necessarily about hearing the same views over and again, rather, it was also the realisation of the recurrence of conceptual models and theoretical explanations that had been discussed in the literature review about well-being, workplace experiences and migrant identities. It is argued that theoretical saturation is not necessarily about numbers but more about making sure that the analysis rests on the assumption that the unit of analysis is the concept, not the person, the group, or the case (Corbin & Strauss 1990). As advised by Baker and & Edwards (2012). I kept identifying and interviewing new participants as long as I was getting different answers. However, at the point of the 23rd interview, I was confident that I had reached theoretical saturation and ceased the interviewing process.

Participant characteristics

To protect the identity and privacy of the 23 study participants, pseudonyms replace original names (Table 5.2 Participant Characteristics).

Table 5.10 Participant Characteristics

Pseudonym	Arrival Visa Type	Current visa	Education	Gender
Martina	Study Visa	Graduate Job Search Visa	General Nursing and Midwifery (HCAQ), Master of Management (NZAQ)	F
Grace	Study Visa	Temporary Work Visa	BS in Nursing (HCAQ), Master of Management (NZAQ)	F
Victoria	Study Visa	Temporary Work Visa	BSc Nursing (HCAQ), Management Degree (HCAQ), Master of Management (NZQ)	F
Megan	Study Visa	Temporary Work Visa	BS in Nursing (HCAQ), Master of Management (NZAQ)	F
Jane	Study Visa	Temporary Work Visa	BS in Nursing (HCAQ), Master of Management (NZAQ)	F
Barbara	Study Visa	Temporary Work Visa	BSc Nursing (HCAQ), Master of Management (NZQ)	F
Donald	Study Visa	Temporary Work Visa	Nursing Diploma, BSc Nursing (HCAQ), Master of Management (NZAQ)	M
Jacob	Study Visa	Graduate Job Search Visa	General Nursing and Midwifery (HCAQ), Master of Management (NZAQ)	M
Edward	Study Visa	Temporary Work Visa	General Nursing and Midwifery (HCAQ)), Master of Management (NZAQ)	M
Levi	Study Visa	Graduate Job Search Visa	General Nursing and Midwifery (HCAQ), Master of Management (NZAQ)	M

Roger	Study Visa	Graduate Job Search Visa	Medical Doctor (HCAQ), Master of Management (NZAQ)	M
Robert	Partner of a Student Work Visa	Temporary Work Visa	Teaching Diploma Business Management Degree HCAQ)	M
Paul .	Partner of a Student Work Visa	Temporary Work Visa	Teaching Diploma, Business Management Degree (HCAQ)	M
Teressa	Study Visa	Graduate Job Search Visa	BS in Nursing (HCAQ), Master of Management (NZAQ)	F
Margaret	Study Visa	Graduate Job Search Visa	BS in Nursing (HACQ), Master of Management (NZAQ)	F
Nandi	Study Visa	Graduate Job Search Visa	General Nursing and Midwifery (HCAQ), Master of Management (NZAQ)	F
Betty	Study Visa	Temporary Work Visa	Nursing Diploma (HCAQ), Levels 3 and 4 Health Care Certificate (NZAQ)	F
Adele	Study Visa	Temporary Work Visa	General Nursing and Midwifery (HCAQ), Master of Management (NZAQ)	F
Jeannie	Partner of a Student Work Visa	Temporary Work Visa	BSc Business Administration (HCAQ)	F
Maria	Partner of a Student Work Visa	Temporary Work Visa	Business Management Degree (HCAQ), Master of Commerce – Management (NZAQ)	F
Alice	Partner of a Student Work Visa	Temporary Work Visa	Postgrad Teaching Diploma (HCAQ), Currently BCom (Economics) NZAQ	F
Sophia	Partner of a Student Work Visa	Temporary Work Visa	Business Management (HCAQ), Master's in Management (NZAQ)	F
Viola	Partner of a Student Work Visa	Temporary Work Visa	Masters in Sociology Degree (HCAQ)	F

Key:

*HCAQ denotes Home Country Acquired Qualification (before arriving in New Zealand)

*NZAQ denotes New Zealand Acquired Qualification

*Participants that had nursing qualifications also practised in the country of origin before immigrating to New Zealand

Table 5.2 shows that a total of 23 participants were interviewed: seven males and 16 females. Seven out of the 16 female participants were Philippine. Of the seven Filipino female participants, five were qualified nurses and two were not. Of the nine remaining female participants, six were from India, and the other three were from three different African countries: Ghana, Malawi and Zimbabwe. None of these three from Africa had a nursing qualification or healthcare working experience before talking up aged care roles in New Zealand. The total number of participants from India is 13. Of these 13 Indian participants, six were female qualified nurses, whilst four were male overseas qualified nurses. Of the remaining three Indian male participants, two did not have

health care training or work experience before taking up aged care roles in New Zealand. The remaining male Indian participant had a medical background after training as a medical doctor in an Eastern European country. His medical qualification did not meet the New Zealand medical practice requirements. Finally, the last three participants were females from three different African countries.

Table 5.11 Participants' country, gender and nurse qualifications

Country of origin	Gender	Number	Overseas qualified nurse	
Philippines	Female	5	Yes	
Philippines	Female	2		No
India	Female	6	Yes	
India	Male	4	Yes	
India	Male	3		No
Ghana	Female	1		No
Malawi	Female	1		No
Zimbabwe	Female	1		No
Sub-Total	Females	16	**Sub Total- Males**	7
Grand Total	**23 Participants**			

All the 23 participants were married, and all had children. Additionally, all the participants held college qualifications and therefore felt overqualified for the aged care job. Participants such as Paul, Viola, Robert, Alice, Sophia, Maria, and Jeannie arrived in New Zealand on a 'Work Visa' tied to their partners' Study Visa. None of the 23 participants had entered New Zealand with a visa tied specifically to be an aged care worker. Several participants had started the aged care roles during the time they were students and had continued in these roles after graduation. All the participants had more than one job. However, the aged care job was the one that provided more regular hours of work and was described by all the participants as their main job.

Researcher positionality and interviews

Merton's (1972) seminal essay, *Insiders and Outsiders* ignited an interesting debate about "who can speak for whom… who can research whom and who can claim authenticity" (Banks, 1998, p.7). Nowicka & Ryan have argued that "Insider

researchers share a cultural, linguistic, ethnic, national and religious heritage with their participants" (2015, n.p.). As a result, "insider" status has been "viewed as the holy grail for the qualitative researcher" (Ganga & Scott 2006, p.7) because it "provide[s] a level of trust and openness" that is usually difficult to attain (Dwyer & Buckle, 2009, p.58). In the same vein, Harding (2004) argued that "strong objectivity requires strong reflexivity" (p.136). In my case, reflexivity was key to my understanding the complex dynamics, which underpinned my relationship with migrant care workers during the interview process. Reflexivity helped me to avoid making stereotypical and clichéd portrayals of the migrant care workers. As argued by Kondo:

> "To merely observe the Other as exotic specimen, or equally unacceptable, to see the Other as a clone of the Self, is the worst sort of projection. Instead, we must constantly aim for a critical awareness of our assumptions and those of our informants, to trace the parameters, the limits and the possibilities of our located understandings" (1986, p. 86).

I was also acutely aware of the dangers of researching a topic, which on the surface, it is easy to ascribe the 'insider' label to me. Therefore, before conducting the interviews, I developed an appreciation of the diverse dynamic and multi-faceted dimensions of researcher and researched relationships. Considering my migrant status, it was unavoidable that I was going to experience being both an outsider and an insider during the research process (Chavez, 2008). From Aguilar (1981), I learnt that insiders and outsiders:

> "…must meet diametrically different demands…the outsider must, to some extent, get into the natives' heads, skins, or shoes, whereas the insider must get out of his or her own" (p.24).

Before conducting the interviews, I therefore critically self-introspected about the possible ways I was either like or unlike my research participant. For example, I critically reflected on which of my diverse identities (migrant care worker, student pursuing higher degree, mother, black race, and poor continent) could advantage, disadvantage, complicate or enrich the interview encounters. My role in the interview process should therefore be understood "in terms of the dynamic rhythms of multi-positionalities" (Ryan, 2015, p.2), rather than simply an encounter between "insider" and "outsiders".

Probably the best way to aptly describe the actions I took to make the interviewing process more productive is to use Ryan's (2015) "dance metaphor" which captures the stuttering and awkward faltering steps between dance partners trying to establish a

harmonious rhythm. In my case, I piloted my interview questions with students and colleagues who did not form part of the final interviewee set. The piloting of questions gave me insights into not only what was potentially important to the migrants but also exposed me to the potential challenges I could expect from the interviewing process. In doing this, I was also showing my commitment to valuing and honouring the views of the migrant care workers that were the direct focus of the study. I adjusted some of my questions because of the pilot study. This was therefore a big part of my preparation for the "interview dance" and it made me confident to take the lead and guide my interviewees in the interview sequence with as little awkwardness as possible.

Equally important is that I did not approach the interviews with a naively unguarded optimistic expectation that my shared migrant status was going to guarantee mutually accepted insider positionality. With some interviewees, I discovered that our shared immigrant status was assumed, but largely unspoken. In other cases, it was made explicit and formed the basis of a particular construction of issues relevant to employee well-being and workplace experiences in the New Zealand ARC. My different personal attributes therefore contributed in different ways in my quest to access cooperation from the migrant care workers. For example, although I shared an insider identity as an immigrant black woman, I also realised that my educational pursuits and employment position located me as an outsider to some of the interviewees. Ultimately, each research encounter involved multiple positionalities, emphasising for example, gender, education, migration experiences, parental and marital status among others. These positionalities tended to have the desired effect of removing the boundaries that would have been created thereby enabling the participants to share their views freely without feeling judged. It is argued that the amount of personal information the researcher reveals to respondents can influence what participants are willing to tell (Miller & Glassner, 1997). I was therefore careful to share with the interviewees only those personal details that encouraged them to share their authentic work experiences.

Researcher bias

An important epistemological issue which has implications for researcher bias is my position as a former migrant care worker. Simmons (1988), as cited in Brown (1996) considers awareness of one's "biases, blind spots, and cognitive limitations … as high a priority as theoretical knowledge" (p.20). As a person who is very close to the issues discussed in this study, a question that arises is how I dealt with my own biases in the data collection process. How did I make sure that I heard and interpreted as objectively as humanly possible, my participants' views and not necessarily what their stories sparked for me? Acting, for example, as an outsider did not "...create immunity to the

influence of personal perspectives" (Dwyer & Buckle, 2009, p.59) nor did the taking of "multiple positionalities". I still had to put mechanisms in place to make sure that I recorded the experiences of my interviewees and not my own.

There were many instances during the interview process when my experiences as a carer mirrored those of the participants. In such moments, I was transported back to the aged care facilities that I worked for previously. For example, I could not resist feeling what the interviewees felt when one of them described how she was still recovering from the trauma of getting into a patient's room and calling out his name and shaking him gently. When the patient did not respond, she discovered that she was shaking a dead body. My eyes welled up. However, I reminded myself that whilst empathising with my interviewee, I still had to retain my position as the interviewer whose role was to achieve thick descriptions of data and depth by establishing a climate for mutual disclosure. I resisted the temptation to capture my own feelings – which I could have easily done – because her story brought back vivid memories of the trauma that I myself experienced when a slightly similar situation happened to me. I consistently reminded myself that my role was to enable the respondents to share their views. In such cases therefore, I asked the participants to share how they felt in that experience.

Thematic Data analysis

Central to qualitative data analysis is the search for patterns and themes (Cohen et al., 2007; Flick, 2013). This is because qualitative research analysis must be guided and informed by "… the questions that were generated during the conceptual and design phases of the study, prior to field work and … the analytic insights and interpretations that emerged during data collection" (Patton, 2002, p.437). Specifically, thematic analysis was used to make sense of the participants' collective or shared meanings. Thematic analysis is a method for systematically identifying, organizing, and offering insight into patterns of meaning (themes) across a data set (Braun & Clarke,2006).

The analysis of the findings took place simultaneously with data collection. This is because analysis is a "pervasive activity throughout the life of a research project... [and] not simply one of the later stages of research to be followed by an equally separate phase of writing up results" (Coffey et al., 1996, pp.110-111). I was afraid of generating copious volumes of data that could overwhelm me and was therefore guided by Silverman's advice that "one interview or recording or a set of field notes are enough to start analysis" (2000, p.121). It was easier to handle one interview at a time and that made it far easier to identify the main themes emerging from the interviews.

Initial analysis took place soon after each interview as I transcribed each interview. This facilitated the capturing of the soul and essence of the interviews.

Creswell's (2009) Thematic Data analysis approach in qualitative research guided the analysis of the data.The approach is made up of six steps: 1. raw data transcription; 2.organising and preparing data for analysis; 3.reading through all data, 4.coding the data; 5.development and description of themes, and 6.interpreting themes. However, these steps are not entirely distinct or discrete categories nor are they meant to be prescriptive, linear, and inflexible rules when analysing data. For example Creswell's (2009) Steps 1 through to 4 in Thematic analysis (raw data transcription; organising and preparing data for analysis; reading through all data, coding the data) were not necessarily discrete but largely intertwined and therefore tended to take place simultaneously.

As mentioned above, the first step in analysing the data involved transcribing the interviews. To develop a robust sense of the interview transcripts, Agar (1980) advised that the researcher should read the interview "transcripts in their entirety several times" (Agar, 1980, p.103). Transcribing and reading the transcripts repeatedly presented me with several advantages. I was for example, able to remember the voice tone that had been used in describing the work experiences including other nonverbal cues that communicated more meaning than the words that were being said. For example, I could visualise Viola rolling her eyes as she described how her 'African qualifications' had failed to land her a job that is in line with her higher education qualifications. Her narration of her experiences of finding a job and the use of the term' 'African qualifications' in a very sarcastic tone, cemented her views about the existence of racism in the New Zealand labour market as well as the structural marginalisation of migrants.

After transcribing the raw data, I read the transcripts several times with the aim of developing a more nuanced understanding of the transcript in relation to the research objectives. After this, I started condensing the transcript. In condensing the transcript, I selected, focused, simplified and abstracted the data available and transformed it into data set that could be analysed in relation to the research objectives (Wolff et al., 2019). At this stage I wrote margin notes of issues that were emerging from my first reading and started using codes. I examined the data for categories that were understandable and meaningful to the research subjects simultaneously coding the

data. Creswell (2007, 2012) defined coding as the procedure of fragmenting and classifying text to form explanations and comprehensive themes in the data.

I condensed the transcribed data using both in-vivo inductive and in-vitro deductive coding (Strauss, 1987). As explained by Carcary (2011), in-vivo or inductive codes are those that emerge directly from the informants' interview transcripts, in other words, they are terms stated by the informants themselves. However, in-vitro or deductive codes are terms the researcher creates to describe a concept discussed by the participant as captured in the transcripts. In-vitro or deductive codes such as 'local qualifications, foreign qualifications, foreign work experience', 'workload', 'racism', 'workload', 'work-life balance' 'training' were generated from literature. At the same time, I was aware that deductive coding could easily close my eyes to new insights in the data. I therefore also built codes using the words of the participants. In examining and interpreting the condensed transcripts, I found that there was a very close alignment between the two codes (in-vitro and in-vivo).

Table 5.3 Example of condensing the transcripts using in-vitro and in-vivo coding

Participant Response	In-vivo codes (direct from participants)	In-vitro code (author's labels)
I have become their friend and I can tell they appreciate me because I can see how happy they are when they see me ...That makes my day as well. It's good to know that someone values what you do…	happy being appreciated and valued	Emotional labour Relationships Job satisfaction
... You see … when I started this job, I really didn't care much about these people…it was just a job. But after some time, I got to know them and some of them are very lovely people. They remind me of my gogo [Grandmother), na (and) sekuru (Grandfather) ku (in) Harare [Viola].	Not caring at first Getting to know the clients Reminded of family	Meaningless job initially Meaningful job later Familial relationships

The coding process and the use development of in-vivo and in-vitro codes show that whilst for academic purposes Creswell's six steps appear discrete entities, In reality, they are largely inseparable from Step ; 5.development and description of themes, and Step 6.interpreting themes

Aided by insights from the literature, as I examined the condensed transcripts, and margin notes, I realised that the literature on workplace well-being in general discusses workplace experiences in relation to well-being by dividing the factors into positive and

negative impacts. Using hierarchical in-vitro coding, as I analysed responses to specific questions, I was able to divide each response into two sections, for example, positive and negative experiences about the nature of the aged care job, workplace relationships and work conditions as captured in Figure 5.3

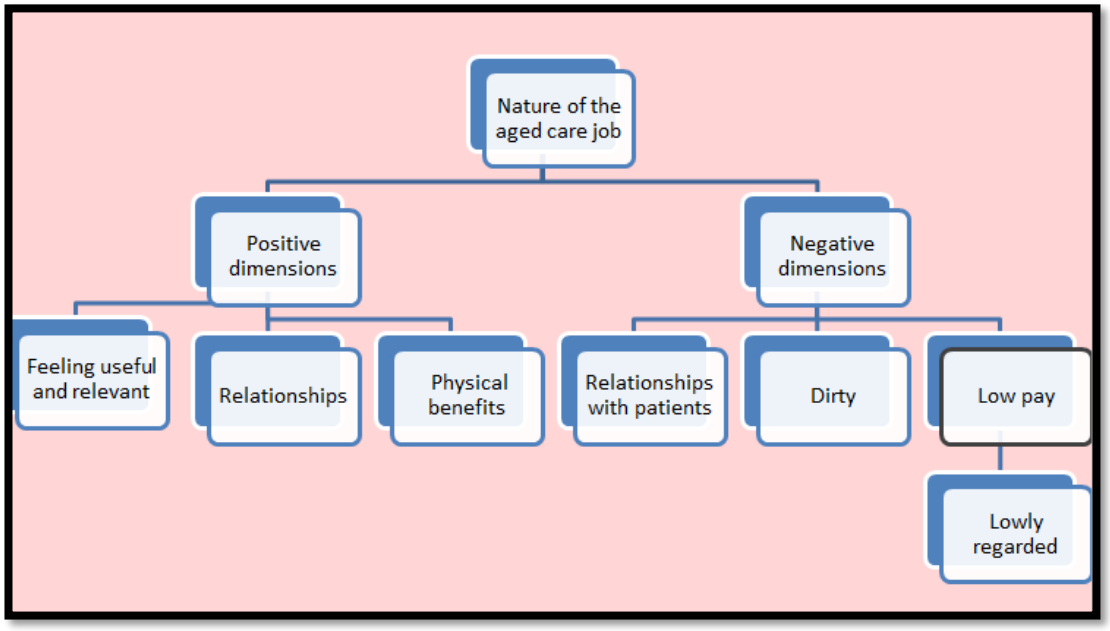


Figure 5.3 In-vitro coding and theme development

At this stage I also identified and described themes in relation to the research questions and objectives. The codes that recurred were clustered together and at this juncture I started thinking at a more abstract theoretical level of themes, dimensions, and the larger narrative- answering the important question about 'What does the data tell me about the intersections between well-being and workplace experiences?' Each cluster built a theme that addressed the research questions. I used the workplace well-being language used in the literature to describe the themes. I repeated this process for all the 23 participants. Finally, as I read and re-read the transcripts in conjunction with the coded material and categories, the themes firmed up and patterns emerged in such a way that I could confidently make connections between workplace well-being and migrant care workers' work experiences across all the 23 participants. I therefore finally integrated all themes from the 23 participants in 'across-participants' analysis, showing the general themes that were found across all the transcripts.

Credibility and trustworthiness

The concept of reliability describes the extent to which results of a study can be reproduced every time under similar conditions with the same researcher or across other researchers (Drost, 2011; Noble & Smith, 2015). It can be argued that essentially

reliability and validity are “tools of a positivist epistemology” (Watling, as cited in Winter, 2000, p.7) which is built around the concept of the world as made up of observable, measurable facts (Glesne & Peshkin, 1992). The interpretivist qualitative ontological, epistemological and theoretical foundations of qualitative research dictate that the parameters that are used in quantitative data analysis such as validity and reliability are not only “irrelevant but also misleading and pointless” (Creswell, 2009, p.190). Reliability is therefore replaced by terms such as rigour, credibility, dependability, trustworthiness and authenticity (Cypress, 2017). The credibility qualitative study findings are concerned with the accuracy of findings from the perspectives of both the study participants and those who read the completed study (Creswell & Miller, 2000; Miles & Huberman, 1994). The credibility and trustworthiness of this study are captured in the rich descriptive details of the research process and the findings, including how they were analysed to generate themes that address the research questions. The rich and detailed or thick descriptions of the interviewing process are intended to allow the reader to enter the situation that I studied and to make judgments and conclusions of the presented materials. These judgments and conclusions may be different from mine because our worldviews are shaped by different experiences. This resonates with my stance on reality that espouses the idea that exposed to the same field findings, the reader of this study might emerge with interpretations and conclusions that are different from the ones I made as the researcher. This is because the consciousness, and the interpretive frames that we both bring to this work, are historically located, and always shifting and evolving depending on the individual concerned (Steinberg et al., 1999).

Additionally, to enhance the credibility of this thesis, I also performed “member checking’’ (Candela, 2019; Harvey, 2015; Yilmaz, 2013). I provided the participants the opportunity to check and evaluate the transcribed notes to determine if I had accurately reflected their viewpoints. Therefore, the results presented in this thesis are credible and trustworthy because they were generated from a rigorous methodological design combined with an analytically defensible qualitative paradigm: Creswell’s (2007) Data Spiral. The questions designed were piloted and proved that they were able to address the research questions. The findings were also produced through a rigorous thematic analysis that emerged with themes that cogently addressed the objectives of this thesis. Sufficient direct quotations are also provided in the Findings – Chapter Six, to enable the reader to make their own conclusions.

Conclusion

This Methodology chapter identified the research objectives that are intended to address the research gap. The chapter discussed the research process focussing on

the value of the critical research paradigm that shaped the conduct of this study. The appeal of critical feminist theory is in its emancipatory focus, to “liberate human beings from the circumstances that enslave them” (Horkheimer, 1982, p.244; see also Cohen et al., 2007, p.26). It further advanced the idea that knowledge has an emancipatory function (Scotland, 2012). The transactional subjectivist epistemology of critical theory accepts that research findings are a result of the interaction and cooperation between the researcher and the researched. The two are inseparable. This is one of the reasons why this theory resonated with me as the researcher and author of this thesis. The inclusion of the ‘self’ in the reflexivity section of this chapter is an acknowledgement that who I am, and the totality of my experiences inevitably influenced various aspects of the study, such as the research topic, interviewing approach, relationship with research participants, as well as the interpretation of findings. As a former migrant care worker, I resonated with the critical feminist theory’s ontological and epistemological assumptions that it is possible to know the interests of ‘others’ without necessarily articulating a personally privileged account. Therefore, my interaction with the interviewees was part of the dialogic and cooperative generation of knowledge and not necessarily a source of bias. As a result, the most appropriate method was the face-to-face interview technique because it enabled elicitation of rich and detailed material that were used to produce the findings presented in Chapter Six. It is in this context that the following chapter will present field research findings about migrant care workers’ workplace experiences and well-being.

Chapter Six: Findings

> *"There are only four kinds of people in the world: Those who have been caregivers; those who currently are caregivers; those who will be caregivers; and those who will need caregivers" (Former US First Lady, Rosalynn Carter, as cited in Michel and Barnes (2019)*

Introduction

This chapter presents findings drawn from migrant care workers in different aged care facilities in cities across New Zealand. As outlined in the Methodology Chapter, 23 migrant care workers were interviewed to examine the nexus between workplace well-being and workplace experiences. Specifically, the study aims to:

1. Contribute to the migrant experiences and well-being theory.
2. Give a voice to migrant care workers whose voices often go unheard.
3. Contribute to practice by suggesting ways to improve migrant care workers working conditions.

The three research questions guiding the achievement of these aims are:

1. How does migrant identity impact migrant care workers' well-being?

2. How do work conditions affect migrant care workers' well-being?

3. How do workplace relationships affect migrant care workers' well-being?

The findings in this chapter demonstrate that workplace well-being was affected by two distinct but interrelated thematic categories of factors. The first one is migrant identity, which is inextricably intertwined with the individual socio-economic circumstances leading to emigration and entry into ARC as well as issues of race and lack of the host country's acceptable soft employability skills. These circumstances had a knock-on effect on the participants' entry into aged care and the subsequent behaviours of the migrant workers in the workplace. Ultimately, migrant identity is characterised by a state of 'lack' and 'lack of belongingness' which compound the precarities and vulnerabilities of their migrant lives with huge implications for workplace well-being. Another significant factor in migrant identity is the role of the temporary legal visa status. In short, all these aspects contributed to the building up of migrant identities that are characterised by vulnerability and precarity with substantial impacts on their sense of security at different aged care organisations, and ultimately, their workplace well-being. The second and final broad thematic category of factors is encapsulated in the concept of the quality of the work environment and its intersection with workplace well-being. These factors underlining the quality of the aged care work environment include the physical, psycho-social and emotional aspects of the aged care job and

management practices around issues such as; orientation and training, workload, staff scheduling and rostering, work intensification, the level of job autonomy, manager support and pay levels. Other critical aspects of the quality of the environment in the context of workplace well-being includes the nature and quality of relationships between participants and their managers, co-workers, residents and family relations of residents.

Migration circumstances, precarious migrant identity and well-being

Workplace well-being was intricately intertwined with the participants' precarious migrant identities, the latter born out of a combination of factors. For example, migration of the participants was informed by the twin forces of 'lack' or constraints within the home country, and perceived abundance of opportunities within the host country. The most critical personal experiences accounting for migration therefore included the constrained home socio-economic and labour market opportunities that made it difficult for them to live a standard of life they desired. These individual circumstances had a knock-on effect on not only their entry into the aged care job, but as well, their reactions to many aspects of the quality of the work environment that impacted their workplace well-being.

> *I came to New Zealand in search for a better future. It is not easy in my country. Life is hard, so I came here for a better life especially for my kids. That is the case with so many of us from my country ...* [Barbara].

As a result of the largely negative emigration circumstances, several participants felt pressured to take up any job regardless of whether it was commensurate with their qualifications and previous work experience. The negative and constrained socio-economic circumstances of participants are evident in that several participants did not have enough money to finance their migration to and resettlement in New Zealand and had to rely on borrowings from banks, friends, and extended family. As a result, they felt compelled to quickly secure a job both during their studies, and after study completion, to enable them to pay off the loans and avoid large interest accruals:

> *My family helped me to find my way here. Many of us borrowed a lot of money… I could not be choosy and had to take up this job…* [Roger].

> *I started this job when I was a student; I did a lot of juggling of study, work and lectures. I was able to help my family* [in the home country] *as soon as I arrived here* [Adele].

Therefore, burdensome past or negative personal pre-migration circumstances continued to influence how the migrants interpreted their current environment and decision-making or course of action in the host country.

Secondly, all the participants perceived that one of the reasons that they were specifically in aged care roles was because of their race and the employers' prioritisation of New Zealand work experience and New Zealand academic qualifications. This was very frustrating, especially to some of the participants who had been given a very positive picture of New Zealand labour market opportunities by their immigration agents. Therefore, for many participants, having a job became more important than having a job for which they were qualified in:

For example, Jane, another Indian female overseas-qualified nurse, said:

> *When I arrived here, I had no choice but to be a caregiver... The other jobs, there was no chance for me. The agents who helped me … did not disclose the truth about the job situation in New Zealand. I thought I was going to be a manager in the health sector. That was just a dream. I applied and attended many interviews but, it was regret after regret...They wanted people with New Zealand experience...* [Jane].

In the same vein, after experiences of numerous applications for administrative and management jobs being repeatedly turned down, Viola, a social scientist, particularly found relief in the low entry barriers of the aged care job:

> *I had to put food on the table. But my* African *qualifications were not going to do that. They wanted New Zealand experience everywhere I applied... Not caregiving. I had an interview in the morning. I can't even call it an interview because they just asked me about my visa and that very day in the evening, I started my first shift. That is how I became a care giver...* [Viola].

At the same time, the use of the term 'my African qualifications' points to the role of the migrant identity aspect of 'race' in her not being hired in jobs aligned to her qualifications. The labour market's insistence on New Zealand experience is also perceived as an example of structural marginalisation that serves to channel the migrants into bad jobs.

Finally, the decision to be caregivers for the participants with previous nurse qualifications was also based on the belief that it was the closest occupation to nursing and would not only make their previous nurse training relevant, but also prepare them to eventually enter their preferred profession of nursing:

First of all, I am a trained nurse ... we cannot be nurses here. This is like a steppingstone for us to start from the very bottom as a caregiver. It's not easy… [Margaret].

None of the participants that had arrived in New Zealand as already trained nurses were under the impression that they could practice without the Competency Assessment Programme (CAP) registration. Nonetheless, they believed that their home-acquired nurse qualifications were competitive enough to enable them to secure at least low-level health care management jobs. All the participants that did not have previous nurse training also shared this view that their prospective employers either judged their qualifications as reflecting a lower standard compared to the New Zealand acquired qualification or used their lack of both New Zealand based academic qualifications and New Zealand working experience to mask the real reason which to them was because they were foreigners and of a different race:

"I attended a lot of interviews for simple administrative positions. I always received very good comments about my performance in the interview… 'you are excellent in this and that', but at the end they still did not give me the job… their reason? … 'If only you had a bit of New Zealand experience'…so I don't know why in the first place they invited me to the interviews… I don't think it's only about New Zealand work experience, I think they don't trust our qualifications at all… [Viola].

Therefore, none of the 23 participants had enthusiastically sought to join the aged care sector as aged care workers. The pressure of their largely negative socio-economic circumstances as well as their inability to meet the New Zealand labour market requirements resulted in them taking up aged care roles.

Additionally, except for Grace, Teressa and Victoria, all the participants that had since completed New Zealand studies perceived that their migrant identities accounted for their lack of success in securing low level managerial and administrative roles resulting in them continuing in their aged care roles:

It did not bother me a lot when I arrived here, and they told me that my medical degree was not good enough for New Zealand. I knew that already. But I completed my Master's degree six months ago, and still I can't get admin positions. I can start at the bottom, but it is still the same story, 'No New Zealand experience'. Yes, I don't have that experience, but I also think if I was not a foreigner, today I would be something else and not a caregiver… [Roger].

The personal circumstances of being migrants and lacking New Zealand work experience as well as New Zealand work references impacted on their experiences of work in other complex ways, as reflected in the findings below.

Temporary visa status, migrant identity and well-being

After arriving in New Zealand and securing jobs as care workers, the migrant legal status of the participants subsequently played critical roles in their workplace well-being. All the participants were working in New Zealand on temporary work visas, which required renewal at appropriate times. The uncertainty of their residency status created them as vulnerable workers. For example, because of the temporary visa status, several participants lived with the fear of being sent back home to their countries in the event that their visa extension applications were not successful:

> *I have spent thousands of dollars paying my lawyer, he handles all my applications. You are always stressed ...* [Nandi].

As a result, the temporary visa status significantly influenced how the participants reacted to different workplace events and experiences that were central to their well-being. For example, several participants did not report workplace problems to their managers hoping to stay free from any controversy so that managers could see them as good employees:

> *...You get the visa and you start worrying about next time... some of my managers are very bad ... but I need their support when I apply to renew my visa. I don't want them to see me as a problem...when you complain at work, even if you are right … managers don't like such people... I just don't complain now...* [Edward].

Several participants also reported that because they wanted their managers to support their visa extension applications, they felt pressured to always go along with the decisions of the managers, even if these decisions compromised their well-being:

> *She calls me when someone rings sick ...I leave everything that I will be doing. She thinks I am a very reliable person…But It's not that I want to work every time. Yes, I am happy to get more money, but I also want time for my family. I am just afraid that if I say 'No', she is not going to give me a good reference or will refuse to support my visa application. I missed church the other Sunday ... I couldn't say 'No', so I drove to work instead of church...* [Levi].

This was not unique to Levi as several other participants said that they found it difficult to refuse to fill-in for care workers that did not show up for their shifts, even if that conflicted with their work-life balance concerns. The managers were also important because they were a source of a critical aspect that was missing in their CVs when they arrived in New Zealand – local work references. Therefore, the participants' pre-migration socio-economic circumstances as well as their lack of New Zealand management and administration work experience, references, including the temporary visa status, resulted in diverse layers of vulnerabilities that adversely impacted the participants' physical, psychological, emotional and social well-being.

Quality of the aged care work environment and well-being

A range of factors within the quality of the aged care work environment were critical in shaping the participants' levels of workplace well-being. In most cases, there was always a pregnant pause before they described their experiences of work, and with almost all the participants, they prefaced their responses by fleetingly emphasising the positive aspects of their job. For example, caring for older people was described as a *positively challenging job* (Maria), *rewarding* (Teressa), *valuable* (Martina and Margaret), *worthwhile experience* (Grace). However, after giving this positive context of the selflessness and honour entrenched in caregiving, the participants delved into a detailed description of what turned out to be largely negative aspects of the aged care job. This reinforced the point they had made earlier on that they had joined caregiving largely due to personally uncontrollable factors. In this respect, several participants described how their well-being was significantly impacted by various aspects of the quality of the work environment, such as, among other factors: the physical and manual nature of the aged care job, emotional labour content, shift work, relationships with managers, co-workers, residents, and relations of the residents.

Physicality of the aged care job tasks and well-being

An aspect of the aged care job that most participants found concerning in relation to their well-being, was its physicality. On one hand, there were a small number of participants [Teressa, Betty, Victoria, Jane, Sophia and Viola] who, whilst cognisant of the negative impacts of the physicality of the aged care job, were able to glean something positive from the performance of such physical tasks. These six participants, except for Sophia and Viola, had arrived in New Zealand already qualified nurses. They invariably said that performing the physical tasks and working in a fast-paced environment, especially during the morning when they had to shower patients and feed them as well as clean the rooms, had improved their physical fitness:

> *Caregiving is a tough job, but it has its own benefits too... I have lost a bit of weight. I feel fit now.... I am a casual so it's difficult to plan exercise time, and sometimes I don't eat healthy food, because I have no time to cook... but at least I know when I come to work, I do a lot of physical things that keep me fit. The job is my gym, free gym*... [Teressa].

Sophia, who was diabetic, said that she had struggled a lot with the pace of the job as well as its physicality, but at the same time found the aged care job:

> *...A blessing in disguise, I am diabetic, and my doctor recommends that I do a lot of exercise. So, it has been actually good for me to do a job that forces me to walk and do a lot of physical things… On my own, it's difficult to exercise … but sometimes it* [physicality of the job] *can be too much for me*… [Sophia].

However, the overwhelming sentiment from most of the participants was about distress as they struggled to come to terms with the performance of the physically demanding aspects of the job. For example, the other six participants that had no nurse training found aged care to be a painstaking labour job that presented significant threats to their physical health:

> *It's not easy if you have not done this job before, it's like looking after a baby... You have to do almost everything for the residents, put their shoes on, push them around …, feed them, lift them and so on. The back suffers at the end. It's also hard on the knees and you feel if when you get home...* [Jeannie].

Alice, Paul and Viola complained about the physical demands of caring for *big and heavily built residents* [Alice]. Viola found the job *physically…mentally and emotionally demanding...*

Paul rationalised that:

> *… It doesn't matter which organisation you work for... As long as you do this job, your back will suffer, your knees will suffer. I never felt back pain before, but after a few weeks doing this job, my back, especially here* [pointing at his lower and middle back] ... *Sometimes I struggle getting up in the morning... I don't blame my employer; I think that is what the job is about.*

All the participants that had previous nurse training found the physical components of the aged care job more intense compared to what they were used to as nurses in their home countries. Roger, who had arrived in New Zealand after qualifying as a medical doctor in an Eastern European country described aged care as:

> *…physically very demanding ... you need a lot of physical strength and yaah, you have to be also quick because sometimes you have to lift the eeeh, heavy residents. I help a lot of the women to lift the residents; I can't say 'no', 'coz I know they need my help…* [Roger].

Levi described the physical aspects of personal care as *very difficult.* Even though earlier on Betty had identified the physical health benefits of age care work, she echoed Jacob's concerns about feeling overwhelmed by carrying the *dead weight* of some of their residents that could barely do anything on their own. In the same vein, Barbara said that although there were many similarities between the work she did as a nurse in her home country and what she was expected to do as a care worker in New Zealand, she, like several others such as Megan, Jacob and Adele, perceived that her extensive nursing experience had not prepared her adequately to deal with the physicality of aged care work. There were *too many physical things to do in just one shift* which caused her a lot of physical pain. Therefore, notwithstanding the physical health benefits of performing physical personal care that a few participants experienced, the rest of their experiences of the physical aspects of personal care were dominated by negative narratives.

Heavy workload, understaffing and well-being

Compounding the challenges of the physical nature of ARC work tasks was the perception that the workload was heavy, an issue that was exacerbated by understaffing per shift. All the participants invariably described their workloads as *unbearable* [Teressa, Jeannie and Betty]. They also said that at the end of most of their shifts, they felt *extremely tired* [Viola] and *fatigued* [Maria, Alice, Teressa, Adele, Jane and Barbara].

The heavy workload was attributed largely to the patient-care worker ratio which they felt was determined without paying due consideration to the unique complex personal care needs of some of the residents:

> *...Some of the patients are … difficult to deal with and sometimes you spend too much time feeding or showering one patient. I have to be very fast in everything I do because if I delay, they* [the other patients] *will start ringing their bells. The managers don't like that* [Jane].

Victoria complained that her job description was too wide as it included too many things, such as cleaning the rooms, laundry, and attending to the personal care needs

of the residents. She said that she was doing too much and that the situation could be improved by *hiring more staff*.

The well-being impact of the physical aspects of care, as well as the heavy workload, were also either ameliorated or exacerbated by the availability and use of physical job equipment, such as hoist machines and sling belts, as well as protective clothing. On one hand, seven participants reported that they had supportive managers and that these managers had made sure that the workplace was adequately resourced to support their performance of the daily aged care routine personal care tasks. These included husband and wife, Robert and Megan (same organisation), Martina and Teressa (same organisation), Margaret (different organisation), Donald (different organisation] and Viola (another different organisation). For example, Robert, who later expressed his disgust at having to clean and shower old patients and regularly deal with their various bodily excrements, said that his job had been made a bit easier by the availability of the protective clothing. As a result of the availability of physical job equipment, these participants performed their roles and duties with minimal fear of infection or hurting both their residents and themselves.

On the other hand, the other 17 participants said that the aged care homes they worked for commonly experienced shortages of incontinence pads and protective gloves. The lack of incontinence pads meant that in most cases, by the time they attended to their residents, they would be extremely wet, which ultimately made their cleaning job difficult. For example, Betty, who, like Adele was extremely conflicted about being an aged care worker on account partly of the nature of the personal care, said that:

> *… How can we do a good job without gloves, pads…We can't perform miracles.* [Betty].

Due to erratic supplies of protective clothing, Victoria was afraid of contracting infections from residents that had *bed sores* and other diseases:

> *Without gloves it's very easy to be infected. So that worries me a lot as a nurse. I make sure that I buy and carry my gloves to work, just in case* [Victoria].

Although Martina praised her organisation for providing gloves, she was nevertheless uneasy about the health hazards she was being exposed to because there was no policy in place requiring care workers to wear masks at work [This comment has no connection to COVID 19. The interview was conducted well before the outbreak]:

> *We have lots of people with infectious diseases and respiratory diseases, but we do not use masks, so you just really need to take care of yourself like taking your vitamins. They don't require the carers to wear masks because this may offend the residents*…

All the participants understood that the very nature of the aged care job required them to assume responsibility for caring for residents' intimate personal functions. Nonetheless, they also strongly felt that their organisations could have done more to make them feel safe at work by providing enough basics, such as gloves and adequate pads for residents:

> *You can ask from other caregivers, or you can turn the one that is used back to front and inside out...not a nice thing, but what to do?* [Jane].

Jane's views were echoed by Barbara, who said that the limited supply of pads showed that some of the managers *don't have a lot of empathy for the residents or us the employees* because *they don't deal with them* [residents] *like we do.*

Nature of personal care and well-being

The challenges that the participants experienced extended beyond the physical nature of personal care to encompass the bodily reactions that were triggered by the raw nature of the work, such as nausea and vomiting, especially in the early days of joining the job. Additionally, even though the participants accepted that the presence of bad smells in the workplace was unavoidable due to the residents' diminished abilities to control many functions related to faecal and urinal incontinence, several participants struggled to adjust to the daily routine of cleaning human excrement. Thirteen out of the 23 participants – all the seven that had no previous training and six overseas qualified nurses – found it extremely uncomfortable doing *dirty,* [Levi, Donald, Edward, Roger and Jeannie] *disgusting,* [Adele], *shocking*, [Viola, Sophia and Robert] *rough* [Maria], *very disturbing* [Sophia, Jeannie and Alice] and *smelly* [Adele, Levi, Donald, Roger and Edward] aspects of personal care.

The personal care tasks of *toileting, undressing and dressing the residents* [Alice] *brushing teeth, cleaning dentures, dressing wounds, and emptying the commode* [Jeannie] were consistently singled out by several participants as intensely *awkward* [Jeannie, Viola], *uncomfortable* [Alice, Maria, Sophia, Robert, Levi and Paul], and *unpleasant* [Maria], especially during the early days of taking up the aged care roles:

> *I had imagined it was going to be like that, but it's different when you actually do it. You cannot … you can never be ready for that...* [Sophia].

In the case of Maria, she was still struggling to successfully adjust her perceptions of, and attitude toward urinary and faecal excrement and the associated bad smells. She was, for example, still struggling to expunge the memory of dealing with a dementia patient who soiled himself and used the excrement to paint the walls in the room and the nearby corridor. In the same vein, Paul also struggled to deal with the feelings of revulsion arising from handling or cleaning body fluids and vomit of the aged residents. He recounted graphically how a patient he was toileting:

> *urinated on my hands as I was helping him to undress... that … is unforgettable... I live with it...Maybe those who are trained as nurses know how to deal with that…*

As a result, several participants said that for many months after starting the aged care job, they had struggled to have a normal meal after their encounters with their residents' bodily excretions.

The five overseas-qualified nurses that registered extreme discomfort with the handling of urinary and faecal incontinence included Adele and the four males, [Jacob, Donald, Levi and Edward]. Roger, the Eastern European trained medical doctor, also found the cleaning of residents' bodily excrements very discomforting. Invariably, these participants said that they had frequently encountered uncomfortable situations associated with urinary and faecal incontinence management in their previous jobs as nurses. Nevertheless, their job descriptions did not include toileting patients or showering them as was the case with their current situation where such tasks were the core of their job:

> *Yes, I am a trained nurse, yes, I have seen vomit and sometimes cleaned it as well* [in the hospital ward]. *But in my home country, a nurse's duties did not include toileting …. We had orderlies...* [Adele].

The inability to delegate the cleaning of bodily excretions or to distance themselves from incontinence management as they had done in their previous nurse roles in their home countries was especially concerning for all the male overseas qualified nurse participants:

> *When I did my nurse training, I don't remember us spending a lot of time on such issues* [faecal incontinence management, toileting and cleaning patients]. *We had assistants for those jobs … That is the big difference. This job is all about cleaning and wiping bottoms… emptying the commode…* [Donald].

However, the reasons for the male's tensions emanating from dealing with residents' bodily excretions extended beyond the inability to delegate the tasks to other people to encompass their deep-rooted beliefs about job types and gender roles, and the social status representations of the aged care job. This theme is presented in detail under the subheading *aged care job social status and well-being**.***

The remaining ten female overseas-qualified nurses, such as Barbara, Grace, Megan, Margaret and even Betty who was generally negative about her role as an aged care worker, expressed slightly different views about how they felt about this personal care:

> *I can't say that is the most exciting part of my day at work. No-one really likes to clean another person's mess… I mean these are adults, so it's certainly not a comfortable thing to do… but it is part of the job. I never did that as a nurse* [back home]*… Here I do it every shift …but I can't say it is a big issue for me…* [Betty].

These female nurses said that they were not extremely bothered by the nature of most of the personal care because the tasks were not radically different from what they had always done as nurses in their home country. Barbara, who had earlier on complained about the physicality of the aged care job tasks, said that the nature of most of the personal care was not very different from what she used to do as a nurse in her home country:

> *The difference is small, as a nurse I normally administer medicine and most of these issues such as cleaning patient vomit are done by nurse assistants or orderlies. But I have done that before …Yes, it is not pleasant… these are old people and not babies…it's never going to be easy to deal with those things* [cleaning their bodily excrements]. *… So, I can say there is really nothing new here* [personal care tasks] [Barbara].

Similarly, Grace appreciated that some people could find dealing with the bodily fluids of old people:

> *…very offending, but I have been a nurse for many years, I can actually have my coffee whilst waiting for my resident to finish his job...* [in the toilet]. *It doesn't bother me a lot. Yes, I remember when I was a student nurse, I cried a lot, because it was just difficult...* [Grace].

Nudity of patients and well-being

Another dimension of the aged care job that is intertwined with the provision of intimate personal care that generated significant negative well-being impacts is the frequent encounters with the nudity of residents. The nudity of residents was not an issue for the overseas-qualified nurses. The closest any of the trained nurses came to share a sense of discomfort about the nudity of their patients and the actual condition or appearance of the old bodies is when Jane said that:

> *…It's not comfortable; especially seeing them nude but it doesn't worry me much when you work you don't really notice these things*... [Jane].

On the other hand, all the seven participants that did not have nurse training could not overcome the feelings of discomfort with the old people's nudity and the actual appearance or look of their old bodies:

> *Perhaps you may think I am being silly, but I found it very hard, I still do even now, yes, it's a bit different now, yeah… eehh, a bit better, I mean, eehh, showering the residents and … seeing them, eehh, I mean naked, maybe it's just me...* [Maria]*.*

The three female participants from Africa were uncomfortable with the invasive nature of personal care and nudity of their *old* [Viola] residents because that contradicted their cultural and traditional constructions of the nudity of especially old people:

> *It is taboo in my culture to see old people naked and to do all these private things for them...toileting…I appreciate that is what this job is all about…but I struggled in the first days and even now when the shift ends, I come back home and really force myself to forget what I saw or touched…* [Viola].

In the same vein, Alice found it *very disturbing* to *undress especially the male residents* and to *wipe their bottoms* as was the case with the frail dementia residents that could no longer do that task without assistance.

One of the sources of tension for this latter group of participants is that they conflated their own sensitivities about privacy and nudity with what they assumed to be the sensitivities of the residents around the same issues. As a result, they felt that in the process of personal care, they were intruding into the residents' most intimate space of privacy. They therefore cringed at the thought of being in the residents' position and other people seeing them naked. For example, Jeannie:

> *… did not feel right to undress and shower an old person. I don't know how to explain it, but I am still struggling with that...I sometimes think about how I would feel in that situation. I just feel that it's too much for me and for the patient, but that is the job, you have to undress them, wipe their bottom, help them with everything, the toilet, eating, walking... I mean, that is what the job is about...* [Jeannie].

Likewise, Paul and Alice struggled to find the right balance between the provision of personal care (which invariably involved seeing and touching naked residents) and respecting their privacy boundaries:

> *Some of them refuse to take off their clothes. I guess it's because they are not comfortable being undressed and showered by someone else. I think many of us forget that these are adults. Yes, they can't do much on their own, but they are still adults. I don't think it is easy for them to be in that situation… I know I would not like someone else to undress me and do all those things for me..., I understand them…* [Paul].

> *I have to stand and watch the patient in the toilet ... It was very strange for me especially in the early days...I still am not comfortable ... you never get used to that* [Alice].

For many participants – especially those without nurse training – the lines between what they believed were the privacy maintenance concerns of their residents and their [participants'] personal concerns and beliefs about privacy and nudity became too blurred, resulting in significant experiences of tension.

Aged care job social status and well-being

The participants' discomfort with the physical aspects of care extended beyond the physicality of aged care, frequent encounters with old peoples' nudity and the bad smells associated with aged care, to encompass other negative social and psychological disorientations. On one hand, although they were struggling to successfully adjust their perceptions of, and attitude toward management of bodily excretions, all the participants experienced significant satisfaction from their roles which gave them an opportunity to *help those who can't help themselves* [Grace]. Megan said that she was *genuinely happy* to be in a position to help the old people. Viola, a social worker, who had previously worked with disadvantaged young people in her home country, whilst not happy about some of the confronting aspects of care work, was pleased to be able to help the residents:

> *... there is something about this job that makes you feel relevant as a human being. I look after people that cannot look after themselves...* [Viola].

Additionally, at a personal level, all the female participants, except Adele, were not overwhelmed by the perceived low status image or lack of prestige of the aged care job. Instead, they chose to focus on the positives of the job. Individually, they had no misgivings about being care workers, but what they believed were their families and circle of friends' negative attitudes towards the aged care job had a bigger impact on them. For example, Martina said that although she was not ashamed of her caregiver role, she was nonetheless:

> *…more concerned about my family. They don't take it well, so I just avoid talking about it.*

In the same vein, Grace, who had also expressed her love for the *noble and worthwhile* aged care job, said that she was also concerned about the *shame* that she was bringing to her parents if word got out that she was a *caregiver* after training and practicing as a nurse before emigrating to New Zealand:

> *I don't consider it a shameful job, I like it, but uhhmm... my own parents, and they would not understand it if they knew that I have been doing caregiving ...*

The conflicted position of these female participants at being care workers was evident in their reflections on instances when someone had asked them: 'What do you do for work?' or 'What do you do for a living?" They said that they were not comfortable disclosing that information to other people:

> *I try as much as I can to avoid that topic, but if someone presses hard, I tell them I am a caregiver…* [Grace].

On the other hand, all the males, as well as Adele and Betty, perceived that doing a job whose core duties involved manual aspects of cleaning and the handling of bodily fluids of old people projected a bad social image of who they are in relation to their *high* [Roger] educational accomplishments. This latter group attached indignity to not only the role of aged care worker, but also to the performance of continence care and other physical and manual aspects of the job. For example, Levi called it a *low manual job*, whilst Betty thought that the low entry barriers showed that aged care work was *not very different from the work done by housemaids.* Concerns about how the rest of society viewed aged care partly contributed to experiences of tension among the participants. For example, Adele's concerns about being a care worker extended beyond the low educational entry requirements for the job:

> *… People… think that when you do such a job, you are not educated or something like that…* [Adele].

As a result, Donald said that he was not comfortable disclosing the identity of his job to other people:

> *You don't want anyone to know you are a caregiver. I don't mean to say that it's a bad job. I just mean that I didn't go to school hoping that, I mean, eehh, to be a caregiver. My parents did not send me to school so that I could be a caregiver...Yes; it's an important job, very important job... One day I will be in a home too...I will need someone to look after me... but all the people I know, my friends, I can't remember any time where they wished to be caregivers in their lives...* [Donald].

The participants therefore associated the manual and dirty aspects of the aged care job with what they described as *inferior jobs* [Adele] which effectively did not do much to help them achieve the social prestige and recognition that come with being employed. The severity of their distaste for doing a low social status job was evident in the intense frustration with the slow pace of being admitted into and completing CAP so that they could practice as registered nurses in New Zealand. For example, Adele, in sentiments that were shared by Donald and Edward as well as Levi, said that:

> *I thought I would be a registered nurse by now, but I am still having problems with my CAP ... I don't know about you, but in my country, this job is not respected, so I really want to get out of it as soon as I can, but I can't do anything without CAP...* [Levi].

These participants' objections to being aged care workers were partly due to what they perceived as negative social implications of the job on their families' social standing. Additionally, for the men, there were other gender-based reasons accounting for their objections to, and experiences of tension at, being *caregivers* [Roger]. On one hand, they believed that aged care was a manual and menial job and was designated for *servants* [Roger] as well as for *females* [Roger, Levi, Robert, Edward and Paul]. It was therefore not a job they would proudly desire to be associated with as a *man* [Roger]. The source of the men's distress at being caregivers emanated therefore from their socialised perspective that caring work is for women. The intensity of the tension of doing a supposedly female job was made clear by Paul, a male participant who had arrived in New Zealand on the merits of his wife's study visa:

> *.... How do you get used to washing another man's or woman's private parts, this is not what I want… Women, yes, not men! But I have a lot of bills you know, so I do it...My parents also helped me to come here. I can't let them down* [Paul]**.**

In addition to avoiding talking about their jobs with their friends back home as a job stigma management strategy, the men unlike the females, went an extra step by resorting to either *lying* [Donald] or *omitting* [Roger] the details of the identify of their job. When asked to reflect on instances when someone had asked them: 'What do you do for work?' or 'What do you do for a living?', Edward said that:

> *You know what? That is what they want to know because they also want to come here. Uhmm… It's tough I can tell you. Sometimes I lie, but after that I feel bad. I also know that one day they will find out the truth because we are so many from India...*

To manage the social stigma associated with a low prestige job, Donald had not *updated my LinkedIn* profile to reflect the aged care role. Like the other male participants, Donald lived with the perpetual fear of knowing that his lie ...*one day... will all blow up in my face....*

It was ironic that the four male care workers [Donald, Levi, Edward and Jacob] who had practised nursing in their home countries before immigrating to New Zealand were also not happy about being aged caregivers. However, they had their reasons. They said that they had lived with the shame of being called *male nurses* [Levi] in their home country, a label which Edward believed was a reminder that *nursing is generally not for men*. They said that in their home countries, the nursing job was always associated with women and a low social status standing. The frustration of these male participants at being caregivers was worsened by their perception that the aged care role occupied an even worse social standing position than that of the nurse occupation. For example, Edward said that when he immigrated to New Zealand, he felt relieved from the *humiliation* of doing a job in which the overwhelming normative expectation was that it was a woman's job:

> *Most of the care workers are women, so this job is not really a good thing for me…. Many people, especially from my country don't respect men who do nursing ... What about caregiving? ... The job is a nonstarter for many of us from India...Now I work with so many girls from my country... I am back to square one...* [Edward].

Edward's relief was therefore short-lived, because as time passed on, more women from his home country who had immigrated to New Zealand took up jobs at his workplace as aged care workers. This had the effect of recreating the same home environment he had escaped from. Considering that caregiving is *lower than nursing* [Edward] in social status, doing caregiving had significant negative effects on all the male participants' sense of masculine self-esteem. The aged care job lacked socially desirable attributes. All the men therefore experienced stress due to the downward labour mobility process in relation to both working conditions and social prestige by taking up jobs in a female-dominated sector. They therefore struggled to come to terms with their social identity label of 'caregivers', as well as dealing with the confronting dirty aspects of the aged care job.

Spirituality and well-being

Although the aged care job lacked socially desirable attributes, several participants were happy to be in a position of helping the elderly people who could not independently perform most of the basic daily activities of life. The job of looking after the elderly had both personal spiritual significance as well as the belief that through the job, they were contributing to a greater good and making the world a better place.

They expressed feeling a sense of privilege to be in a position of influencing the quality of life of the elderly patients

> *I get so much happiness looking after my residents. I know the pay is not good, but that is what it is with these jobs. I can't really complain. Obviously if they gave me more money, I will be happy, but I am very realistic about this job, so I don't really bother much about the salary. It is what it is...* [Grace].

Although Viola considered her aged care pay very *low*, she found the aged care job more meaningful at a level that transcended the more material concerns of her life:

> *…The pay is not enough, but that really does not bother me a lot… True, money is … very important to people like us in a new country. That is why I took up this job... I have to pay bills and school fees. But the job we do is far more important than money. My happiness is in doing a job that helps others... I am thinking of training as a nurse* [Viola].

Similarly, Martina**,** an overseas-qualified nurse said that:

> ...*Personally, I am not ashamed to be a caregiver... the job is very fulfilling. I am doing an important job. I help people who really need my help...*

Maria said that she was neither bothered by both the status of the job nor the idea of people knowing that she was a caregiver: She said that she had grown to:

... love and respect this job... I believe that the Lord wants me to go through this... at the end of the day, I am happy to live a life of making other people's lives better… That is good for me

Other participants used spirituality as a coping strategy especially with reference to poor pay and other aged care conditions of work. For example, Jeannie found solace in the 'serenity prayer' which helped her to not get stressed by low pay:

> ***...****one of the prayers that helps me every day is 'God, grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference'*

The other participants were disturbed by the patient management practices that contradicted their spiritual beliefs. For example, some of the participants were disturbed by the patient management practices that contradicted their spiritual beliefs. Maria was shocked to learn that the relatives of a patient had given '*do not resuscitate'* instructions to the age care facility if their relative got into some cardiac arrest. She felt that complying with that instruction contradicted her own spiritual beliefs about life and death.

> *"How can you say do not resuscitate a patient. That is what caring is about.. How do you live with yourself...*?

In the same vein**,** in response to the 'don't resuscitate message' Betty said that the relatives were trivialising the life of the old people, and this contrasted sharply with the way the old people were respected and revered in her home country; *"...these homes are very lonely for some of these patients. It is so sad."*

Emotional labour and well-being

Additional to the physical aspects of the aged care job and their associated well-being impacts, the emotional labour content of the aged care role also significantly impacted the participants' well-being. Over time, all the participants, including those who were clearly not happy to be in the aged care role, such as Adele and Betty and all the male participants, inevitably developed strong social bonds with their residents. The metaphor 'roller coaster' succinctly captures the tension between different feelings as participants navigated different positive and negative emotional events, such as close social relationships with the residents, and the death and loneliness of residents:

I have become their friend and I can tell they appreciate me because I can see how happy they are when they see me ...That makes my day as well. It's good to know that someone values what you do… [Grace].

Similarly, Viola, Victoria and Sophia revelled in their positive social relationships with their residents. The residents reminded them of their own families in their countries of origin:

... You see … when I started this job, I really didn't care much about these people…it was just a job. But after some time, I got to know them and some of them are very lovely people. They remind me of my gogo [Grandmother), *na* (and) *sekuru* (Grandfather) *ku* (in) Harare [Viola].

Similarly, Jacob said that the residents had become more than just patients*:*

We all end up being close to our residents. When I see them, I also see my nana [grandmother*) and dadi* (grandfather*)... When I get time, I talk to them. They want to know a lot about me, and I like telling them about my country and culture ....* [Jacob].

The companionship of the patients immensely benefitted several participants who were struggling to both create new social networks of their own in the process of adjusting to the new environment of their new country of residence:

When you first meet them, it can be difficult. It takes time to get used to them. Yes, it's rocky at the beginning, I mean; I think it's just normal, because I am a stranger to them. Yes, some continue to be troublesome, but with others, we become friends, good friends at the end... [Sophia].

The residents were therefore an important provider of several participants' human interaction needs. Several participants shared stories about the many instances when their residents had shown interest in their private migrant lives, especially their challenges of starting a new life in New Zealand:

... With us...it's a bit different. I mean, eehh, these are not just residents; they are people who are important to us because in a new country, it's difficult to make relationships [outside work] [Nandi].

Although Adele had earlier on indicated that she was not happy to be a caregiver, she still acknowledged the social benefits of connecting with the stories of some of her residents:

Yes, it is a difficult job, but I also benefit ... a lot of laughs. You meet great people; you meet great families. I have come across residents that are very educated and they have helped me so much to understand New Zealand life... [Adele].

The 'relationship' aspect of their work was therefore not a one-directional relationship of dependency. The caregivers also drew social benefits from the close social bonds they created during the performance of personal care, thereby reformulating the care worker-patient relationship beyond just giving and receiving personal care. For example, Betty found some of her conversations with several of her residents:

…*very interesting…Some of them remind me of my granny, always ready to give advice… It's unfortunate we don't get enough time with them… sometimes the work is just too much, and you can't afford to sit and talk ….* [Betty].

As a result, several participants complained about management practices around staffing and time allocated to complete complex personal needs of an increasingly frail group of aged care patients which forced them to increase the pace of work leaving them not only fatigued but unable to develop meaningful professional interpersonal relationships with their residents:

In most cases all they need is my company. But I can't give them my time because I am always being rushed... [Maria].

…We are always rushing to finish… and even if the hoist machine is working well, you can't use it because it takes a long time to transfer a patient using a hoist. So, what do we do? We just lift the patient quickly. We know the danger; you can hurt the patient or yourself but what to do? It's very risky. But you know that the manager won't like it if you don't finish your residents on time [Nandi].

Several participants therefore identified inadequate staffing levels as having impacted on not only the time they could spend attending to the personal care needs of their residents, but also how effectively they attended to those needs:

...They have a lot of stories about their life. You can tell they are lonely because they can go on and on talking about this and that, this and that, asking questions about this and that...Yeah, you can tell they are trying to keep you in that room for a little while longer... But I have other patients waiting for me. What can I do...? So, I have to leave before they can finish their stories. I can tell they are disappointed, and I blame myself, but the truth is I don't have time... [Paul].

As a result, several participants reciprocated the kindness of the residents by becoming too involved in the life of their residents. However, this inability to professionally detach themselves from the residents they cared for made it more difficult for them to bear the pain in the event of the death of a resident:

> *... he always told me to be careful when driving in such* [snowy] *conditions. He was always a happy person and would talk about his future and also ask me about my plans for the future... then he died. I have never felt so low in my life. I can't get him out of my mind even now* [Donald].

Due to the strong social bonds created between the participants and the residents, it was no longer possible for the participants not to pay attention to the loneliness of some of their residents that, for example, rarely entertained visits form friends and relatives:

> *Oh, I think it rubs off onto you, you see them seating in the wheelchairs alone and others are being entertained by their relatives. Yes, it rubs into you and sometimes when you finish your shift and you are driving home, something continues to bother you. … I mean when you feel there is something bothering you. But you can't put a finger onto it...and then it hits you... "Oh it's that old man who was seating alone with no one to talk to..."* [Teressa].

> *You feel for some of them because you can see how much they miss their family... but no one visits them... it's like their relatives have abandoned them...but others get visitors a lot. It's up to us to lift their spirits…* [Barbara].

> *I see their misery; I feel it and sometimes I want to cry... I wouldn't like myself or anyone of my relatives to go through that. I can tell you that after you are done with the shift, you can't forget that...You blame yourself, but it's not really my fault...* [Maria].

As a result of these strong social bonds with their residents, several participants found it psychologically and emotionally unbearable to be put in a position of, for example, knowing that their residents were wet, but they could not be changed because of a limited supply of pads. They felt that the aged care system was letting down the *helpless* [Paul] residents:

> ... *We are told to change the pads when they are, I think 75% wet... whatever that means... A wet pad is a wet pad... 20 or 30 or 40 % ... But, I mean, once*

they [pads] *run out, that's it ... it worries me … I know I would not like to be in a wet pad at all...* [Paul].

The participants therefore lived with the guilt of knowing they could not do more to improve the lives of their residents because of the work environment limits.

A concerning issue for several participants was the lack of support from managers in the event of the death of a resident:

... So far, three have died ...but I can tell you that no one really checks on you… I would be happy if someone at work just asked me "How are you? Are you ok"? No one bothers to ask such questions. It's like nothing has happened at all... [Paul].

The downside of empathy is when you develop attachment to the residents ...when they die this affects you. Those who pass away peacefully, you say they are in a better place, but the others struggle... but there is nothing you can do. There is need for training on how to deal with such things [Robert]**.**

As a result, Grace shared Barbara's view that some of the managers *do not have empathy for us* [the employees]. It is worth noting that most of the participants that had no previous nurse training were more psychologically and emotionally affected by the residents' death compared to their overseas qualified nurse colleagues:

Yes, it's emotionally draining … It is hard when they die... but having been in such moments for a long time, you learn to share your sympathy and move on...or you will die of stress yourself... you can't nurse someone else if you are sick, so you need to learn to protect yourself... [Adele].

Training, job preparedness and well-being

The preceding sections of this chapter provide evidence that several participants were overwhelmed by various aspects of the aged care job. The distress arising from doing excessive workloads, of physically and emotionally challenging as well as confronting aged care job tasks, was ether aggravated or mitigated by the nature of training provided, especially at commencing their aged care roles. All the participants identified training as integral to the way they performed their job because it gave them *confidence* [Margaret] that they knew what they were doing, as well as *peace of mind* [Teressa]. On one hand, seven participants – five of them overseas qualified nurses [Megan, Martina, Teressa, Margaret and Donald] and the other two without healthcare

training or work experience [Robert and Viola] said that they had received intensive training which helped them to quickly acclimatise to the new aged care job demands and the aged care work environment:

> *…. We were three when I joined and all of us had never been caregivers before. But the manager was very patient with us..., so training, I can tell you, was very useful for me...* [Robert].

> *It was my first time to use a hoist. We were … taught … how to deal with different patients… how to deal with the relatives of the patients, and our colleagues* [co-workers]. *They also taught us about how to handle Maori residents because they are very sensitive about their culture*... [Megan].

Additionally, these few participants lauded the use of the 'buddy' system during their orientation. As new recruits, they found it easier to ask a 'buddy' question than would have been the case if the whole orientation had been conducted by the supervisors and/or managers.

> *I could ask as many questions as I liked, I don't think I could have done that with the manager…* [Megan].

Although they were qualified nurses, Margaret and Teressa said that training helped them to adjust to the requirements of the aged care role:

> *…even if you have a lot of nursing experience, you need a lot of training... how to deal with old… residents who can't do simple things for themselves....* [Margaret].

> *...I have been in the nursing field for quite some time now, … Nursing and caregiving are not exactly the same, yes there are many things that are similar...The training really helped me a lot to adjust...* [Teressa].

The remaining ten overseas qualified nurses, as well as Roger the Eastern European trained medical doctor, complained that their organisations assumed that because they had a nursing or medical qualification, they did not need much training:

> *There are many things in aged care homes that I have never seen or done before.* [Nandi].

> *.... We did a walk around, seeing the wards and patients. I was told to report for work tomorrow...It was like they thought I knew everything about the job…?* [Adele].

The remaining five participants without any healthcare training, complained about the quantity and quality of training. Alice said that although at the time of being hired, she had indicated to the managers that she had no heath care work experience or training, they did not take this into account:

> *...I expected them to give me good training…we walked around, and they introduced me to a few…patients. That was it...We need to be trained thoroughly to look after people, especially for a person like me with no knowledge about this caregiving* [Alice].

As a result of limited training, Maria and Paul experienced guilt for not providing adequate care to some of their patients who had bed sores:

> *I just didn't know how to do it and no one had shown me how to deal with such patients. Later I asked another caregiver... a qualified nurse and she helped me a lot ...* [Maria].

> *It seems easy when you are told that you are to change their pads... but no, it's not easy I can assure you… This was new to me. The training did not cover such things, so I had to learn from others...* [Paul].

Another source of frustration which many participants felt could have been avoided through proper training was how to interact with the clients who were culturally different from them. Although none of them experienced English language oral communication challenges, they were not confident about developing interpersonal professional relationships with the residents:

> *I think it is important, especially for us as the professionals, to know what matters to the patient. Small things like introducing ourselves to the patients, how to talk to them, what to talk about and listening to them during care. The training did not cover these issues. Perhaps they thought since as we are trained nurses, we know everything, but we don't...* [Jacob].

Several participants therefore suggested that the training and orientation activities needed to be adjusted to accommodate their unique experiences as migrant care workers who had little exposure to aged care. Overall, therefore, a lack of, and inadequate training in various aspects of aged care service delivery in a multicultural environment increased the negative workplace well-being impacts of the various aspects of the job.

Shift work and well-being

Working shifts caused various social, physical and emotional well-being impacts for the participants. The participants were asked: 'Have you experienced any challenges in meeting your social, family, religious or any life commitments because of your role as a care worker?' All the participants provided both negative and positive examples of intersections between their job and family life, parenting, social and religious participation. For example, the six Indian female married participants [Barbara, Grace Jane, Martina, Megan and Victoria] shared countless moments when shift work either facilitated or complicated their ability to meet their study-life commitments since the time they were students and after completing their studies in New Zealand:

> *…When you do shifts, there are advantages and disadvantages. When I was studying, I could do night shifts and do my schoolwork during the day…. Of course, sometimes it was tough to focus, so I sometimes, I mean, ehh, I just spent the day sleeping instead of studying… but now I am not studying anymore and wish I could just have a normal job, I mean work from 8 to 5...* [Jane].

At the same time, these six Indian mothers, like all the remaining 17 participants, found that regular night shifts with limited rotation facilitated a better management of their non-work life commitments:

> *Most of shifts are at night. It was very difficult at first, but now I can organise my life better. I know that during the day I am free most of the time. I clean at the Mayor's offices, only 3 hours, Monday to Friday, 5pm to 8 pm, then my usual shift from 11pm to 7 am. That gives me a lot of time to do other things during the day*… [Barbara].

These experiences of shift work were also shared by Martina:

> *…It is not the same here. You see, in my country, umm, I did a lot of night shifts, but I had time to sleep during the day. There were many people who helped with cooking and kids or cleaning the house… but here it's just me and my husband… I can't just go to bed when I come from my night shifts; there is always work to be done…so it can be tough sometimes…* [Martina].

Working shifts had negative emotional health effects on Jane because of lack of fit between her work schedule and private life commitments:

*I miss my kids, especially the youngest...He is three and I feel like I have missed a year of his development... and I am not always there for my little boy**...*** [Grace].

The biggest social benefit for six female Indian overseas qualified nurses was that they were able to share childcare responsibilities with their husbands, who ordinarily would not have taken up such responsibilities back in their home country:

.... He is bonding very well with our kid. I love shift work. Back home he didn't do that… [Victoria].

This was corroborated by Jacob, who said that shift work had made it possible for him to play a more active role in the lives of his children *unlike back home*. At the same time, just like the other Indian male participants, he struggled to adjust to their increased participation in domestic chores:

Yes, shift work has its advantages, but to be realistic, there are also problems there...I now do a lot of things in the house that I never used to do... [Levi].

Ironically, this tension was also shared by the same six Indian female participants who had earlier on described shift work as beneficial to their work-life balance concerns. The six participants were extremely conflicted because shift work was increasingly making it difficult for them to perform their culturally entrenched familial traditional domestic roles such as cooking, laundry and general upkeep of the home:

...In my country, men don't think or worry about "What to eat today?" or "What to cook today?" That is a job for mothers or wives ... Shifts make it difficult for me to play my duties as a Hindu mother and wife. I can't ask my husband to cook or do laundry. Nooo!... [Martina].

The remaining participants also shared conflicted views about working shifts, primarily because it resulted in a lack of opportunities to meet some of their important social, family and religious participation needs:

I think now it's a bit better, it was tough for me when I arrived in this country. Although there are a lot of Zimbabweans here, I could not get time to meet them. Everyone is busy and the time they are able to meet is Sunday at church…, but I could not because of my shifts… so it was just me and my husband our kids…. No-one wants that… [Viola].

Similarly, Sophia described rotating shifts as detrimental to her sleep patterns and ability to organise or attend sports activities for her children, as well as private social functions:

> *If I had fixed shifts that would be better, but they are rotated. Sometimes I am in the morning shift, and …the next time I do a split shift, short shift double shift…* [Sophia].

When night work was performed as part of a rotating shift schedule, it therefore caused significant challenges to sleep patterns and fulfilling childcare obligations. For example, Paul was afraid that his work commitments were making it extremely difficult for him to closely supervise his children. He was afraid that they were going to *visit bad websites that do pornography.* His unscheduled shifts and other retail job left him very fatigued and therefore spent most of his off time sleeping leaving his children mostly unsupervised. This was also the case with his wife who also had two jobs.

Working irregular shifts had also caused some participants to develop unhealthy and poor eating habits as a result:

> *I eat lots of junk food because I jump from one shift to the other. No time for the gym...no time to prepare food.* [Jacob].

The participants' experiences of shift work and the subsequent impact on well-being were therefore varied. However, most of the participants were concerned about the mostly negative impacts of shift work on personal, family, life, and work balance.

Pay and well-being

The other aspect of the quality of the work environment that impacted on the well-being of participants was the level of pay. On one hand, whilst acknowledging that pay rates were very low, and that had also in turn made it difficult for them to meet their living expenses, seven participants with previous nurse training and three without previous nurse training did not view pay as a significant stressor to their lives. For example, although Barbara and Grace had earlier on indicated that the aged care job left them feeling fatigued and that the workload was *unbearable*, their love for the caring profession influenced their views about it:

> *There are many more worrying issues with the job, I mean, the job is not easy to do, that is a fact! There are many things about this job, eehh, that are not pleasing to do and I can understand when some people say that the money is not enough, but this is a job that you do because you love what you do. For me it's a calling. My mother is a nurse, my other two sisters …I mean, eehh, they*

are also nurses. We are a family of nurses, and we enjoy what we do... [Barbara].

Jeannie reasoned that it was futile for her to agonise over low pay in aged care because she had learnt from some of her friends in the UK and USA that the aged care jobs were poorly paid. As a result, low pay was not a significant stressor:

> **...***one of the prayers that helps me every day is 'God, grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference'. I know that this job does not pay well, so I don't think it's about New Zealand, I think it's a global thing. Care workers are not paid a lot of money... everywhere…. I know I can't change that; I can't worry about things that I can't change...* [Jeannie].

In the same vein, whilst acknowledging the importance of a competitive pay to their new life as immigrants in a new country, Jane and Donald said that they did not dwell so much on the issue of the *low* hourly rates:

> *I have three jobs. Yes, the money is little, but where and when is it ever enough? …When I do my CAP and get my registration, I will still do more jobs or take more shifts, so I don't think that the rates are low or they are good... I worry more about not getting enough sleep and not being there for my kids...* [Jane].

However, the other participants were unequivocally clear that low pay had significant negative well-being impacts arguing that the pay rates were not competitive, especially in relation to the demands of the job:

> *I think that the job takes a lot out of you. It affects you emotionally, physically and socially. I was once a primary school teacher in my country, and I used to feel very tired – physically and emotionally – dealing with those kids. This job is … more demanding... Yes, I have no qualifications for this job, but I think whoever does this job deserves a better wage than we get now...* [Robert].

Several participants justified their dissatisfaction with the wages they were getting on the basis of not only how difficult and complex the aged care job tasks were, but also the importance of the job:

> *I don't think any one of us is satisfied with the pay... I think the money is too low. We take care of people who can't look after themselves. They are our parents, grandparents, and we will all one day be in those homes. I think the*

low salaries show that they don't care about the old people and us, the caregivers. [Megan].

The other participants who had arrived in New Zealand already qualified nurses, wanted the pay schemes to recognise their specialised nurse training qualifications and skills. The participants therefore felt structurally marginalised by a system that refused to recognise their previous nurse training but allowed them to do everything a nurse does in an aged care facility, for example, administering meds. However, because they were not yet accredited, they were paid as if they have no nurse training at all.

I think it's unfair that as a trained nurse, I am paid like that. They want us because we are trained already. They know we are going to do well looking after their people, but when it comes to paying us, they use the excuse that we are not registered nurses here. I think it's unfair. We should be paid better [Adele].

Workplace relationships and workplace well-being

Finally, the participants' well-being was significantly affected by the nature of relationships with their managers, residents, relations of residents, and co-workers. On the one hand half of the participants felt supported by their managers whilst others had poor relationships with their managers. The participants who felt that they had good relationships with their managers gave examples of how their managers allocated to them their [participants] preferred shifts, as well as ensuring that they were treated fairly and felt valued.

Although Martina and Megan complained that the low levels of pay made them feel less valued in the workplace, they were nonetheless pleased about the level of attention their managers gave to other aspects of their work-life. They talked about being *heard* and *listened to* [Martina] and being *cared for…* [Megan] by their managers:

The manager is fabulous. I think she likes migrants better than the locals ... We are hard workers... there were only four immigrants when I started, but now, we are the majority... [Martina].

Megan felt:

… accepted because last time, they selected me as the 'employee of the month', and I was very happy...

Several married participants with school going children cited the way some of their managers had helped them to balance their work and childcare commitments as an example of good social relationships with the managers:

> *She knows our challenges as immigrants and she tries her best to, eehh, with the roster, eehh, I mean when I ask her to put me in the afternoon, she does that and if I am comfortable at night; she gives me night shift... She does not do that to me only... Another friend, a Filippino has kids going to school and the manager helps her too...* [Margaret].

Similarly, Nandi who worked for a different organisation to Megan or Martina's described her manager as:

> …*a very fair human being. She treats us equally whether you come from New Zealand, India, Philippines or Africa; she just treats all of us as human beings...* [Nandi].

However, the other 12 participants said that their relationships with their managers were strained. They complained that the managers did not provide an inclusive and supportive work environment. They, for example, perceived discrimination and favouritism in the way shifts were allocated, as well as the way managers responded to the migrants' workplace concerns in relation to the locals. They perceived that their white care worker colleagues were almost always allocated the 7am-3pm shift or any other shift they preferred. The 7am-3pm shift was the most popular especially for participants with school going children, because it allowed the care workers to:

> *…live a normal life. You can dismiss work and go pick up your kids from school and cook for the family... You live a normal life like everyone else...* [Victoria].

For example, Edward could not understand why a Kiwi care worker colleague had not been allocated any one of three particular residents, two of them who had a reputation of being difficult and uncooperative during personal care delivery:

> *... At first, I thought maybe they were allocating them to me because of my physique as a man. But no, because two very tiny girls... they come from India just like me... they were also complaining about the same patients. They also noticed that the local care givers never got those difficult residents on their list* [roster] [Edward].

The issue of perceived unfair allocation of heavy workloads and perceived lack of seriousness of managers towards resolving migrants' reported abuse cases by patients, emerged as strong indicators of the way the participants assessed the quality of their relationships with the managers. It was an indicator as to the extent to which the managers cared for their well-being as well.

The other participants felt that the *small mistakes* [Paul] they made during personal care were usually blown out of proportion compared to their white colleagues. For example, Sophia felt that her manager had reprimanded her more severely than her white colleague who had committed a far more critical error by forgetting to update the resident's record book about the meds that had been administered:

> *… There was no shouting like she had done to me* [Sophia].

There was also the perception that some of the managers trivialised or totally disregarded their complaints about being abused by patients. They perceived that this unfair treatment was tied to their immigrant status as clearly expressed by Barbara:

> *... If we are harassed by a resident, they go on the side of the resident... sometimes they ignore us completely...*

The use of the plural 'we' by Barbara in the statement above shows that she believed that in general, migrant care workers were not treated equally in relation to their local-born care worker colleagues at her workplace. Levi who worked at a different facility, also used the collective pronoun 'we' to reflect his belief that such occurrences were not restricted to him only but also to other migrants at his workplace:

> *We have few[er] options so we keep our mouths shut...*

Levi and Viola recounted instances when they had been verbally abused by their residents but because they did not trust that their managers cared about their feelings, they had not reported the abuse:

> *Some residents ... are very rough to us immigrants. One day he asked where I come from ... And you left your country, to come all the way to New* Zealand to do this job... [Viola].

> *One of them asked me why I am doing a woman's job...? Later he said he was just joking with me, but he was not. I could tell he was serious...* [Levi].

Like many other participants Levi, Donald and Victoria felt defenceless against the deliberately hurtful personal insults that were hurled at them by some patients during the process of personal cares:

> *...Did you cook today? I smell some curry; you need a strong deodorant to kill that stuff…* [Victoria].

The other participants rationalised that the increasingly indifferent attitude and insensitivity of some of the managers towards the welfare of the migrant care workers was a result of the labour market that had an oversupply of immigrants looking for caregiving positions:

> *We used to be only two foreigners and the manager always asked us, "How are, you? How is work? What can I do to help? If you need help, please don't be afraid to ask. My door is always open" ... but now, we are many..., and it's like we don't exist anymore. No more "How are you? Any problems at home etc?"* [Alice].

The reported sporadic instances of discrimination and racism were therefore experienced by almost half of the participants, whilst the other half reported exceptionally cordial relationships with their managers. Worth noting is that the participants that did not perceive racism or discrimination supported their stance by using the same reference points of allocation of shifts and job tasks, as well as the support the managers provided them when they reported workplace challenges:

> *"We know you are husband and wife, but we did not know that you want to work together". And they were happy to give us the same shifts so that we have off-days together...* [Megan].

The other relationships that were significant to the well-being of the participants are the ones they developed with the relatives of the residents. Only five participants reported negative experiences with relatives of the residents. This mostly happened with relatives that did not seem to appreciate the good work the participants were doing in looking after their relatives:

> *Yes, it's their right to want the best for their relatives, but sometimes you can tell that they think we don't look after their relatives well...* [Roger].

Similarly, Edward's experiences with a few of the relatives of the residents left him feeling unappreciated:

> *I do a lot for these residents, but some relatives question everything that I do? What about this, what about that, as if I am in court. They don't know what we go through...; our work conditions are not the best…That makes me very angry sometimes because this job is not easy*… [Edward].

Victoria recounted a *nasty* encounter with one of the relatives who complained to her about her relative who was wet when she visited:

> *She should have complained to the manager, not me. A lot of us actually buy pads for these residents. I buy my own gloves to clean them. We don't have enough pads… we don't have enough gloves. I don't know whether they* [relatives of patients] *don't know that… so I was very angry, but I just apologised…* [Victoria].

However, the majority of the participants had mostly positive experiences with the relatives of their residents:

> *It's always pleasing when they come and they help with feeding, some of them bring us chocolates especially during Easter…*[and]… *Christmas* [Grace].

Sophia valued the accolades she got from some of the relatives who came in to occasionally check on their relatives:

> *…. They ask about how their relative is doing and I am always happy to see such families* [Sophia].

Levi said that he had learnt a lot about some of his residents who for example always objected to being showered early in the morning:

> *I learnt that he never liked showering in the morning or eating before 10. So, I finally understood why he did not like to shower in the morning. Of course, there is nothing I can do, but knowing helps. I can't be frustrated with someone who has lived his whole life doing something, and all of a sudden, he has to change. That is not easy… so less stress for me!* [Levi].

Finally, the relationships with co-workers were an integral part of the participants' well-being. Time permitting, the co-workers came to the aid of each other when dealing with difficult patients or when overwhelmed with the work. Several participants acknowledged the help they got especially from their local born co-workers regarding how to develop professional interpersonal relationships with the residents.

There is a lot of respect between co-workers, and if we have any problems, it is easy to talk to the nurse manager, and if nothing changes, we go to the facility manager [Grace].

Well, I must say that they [co-workers] were very welcoming…You will never feel that you come from a different country or different race. [Jacob].

My co-workers do not wait to be called to … help you; when I need help, they will come and … help. That is why I like it there… [Megan].

Actually, we have a lot of Indians and a few Kiwis, and they are very close to us.... [Barbara].

This collaborative approach to work, especially with the local white care colleagues, was described as having contributed significantly to the positive experiences of not only the immediate work environment but also greater New Zealand, and ultimately their well-being.

Conclusion

This chapter has presented findings about the migrant care workers' perceptions of how their workplace well-being was influenced by their experiences. The findings show that well-being was affected by various factors within and outside the work environment. The various but mostly constricted socio-economic circumstances that led to the participants' emigration to New Zealand and into their aged care roles, as well as the participants' migrant temporary visa status, had long lasting effects on how they interacted with many aspects of the quality of the work environment relevant to their well-being. It was also established that workplace well-being is impacted by various aspects of the quality of the age care work environment, such as the physical nature of the aged care job, heavy workload, understaffing and poor pay, and emotional labour among others. In this respect, the participants that had previous nursing experience were not as overwhelmed as the other participants that did not have any previous nursing experience who were encountering the aged care role tasks for the first time. Finally, relationships with managers, residents, co-workers and relatives of the residents were integral to the participants' well-being.

Chapter 7: Discussion

Introduction

The findings in Chapter Six showed that workplace well-being was influenced by two interconnected thematic categories and associated sub-themes. First, the participants' migrant identities which are products of constrained pre-migration socio-economic circumstances, being foreign and of a different race, possessing foreign qualifications, lacking both New Zealand work experience and New Zealand qualifications, and also holding a temporary work visa, significantly influenced their entry into aged care roles as well as their subsequent responses to workplace issues that impacted their well-being. The participants are in the aged care sector as employees primarily because of the influence of at least two broad factors: the conditions that pushed them out of their home countries combined with the difficult labour market requirements that they encountered in New Zealand. As argued by Thapan (2005) the chief propellant for migration is an interplay between constrained socio-economic and poor employment opportunities in the home country, and perceived abundance of opportunities in the host country.

Secondly, the quality of the work environment; a multifaceted concept which encapsulates physical, psychological, social or organisational demands and job resources, significantly impacted workplace well-being (Arends et al., 2017; Cazes et al., 2015; Gustaffson & Szebely, 2009; Karasek, 1979; Lane et al., 2010; Mohamed et al., 2006; Sell & Cleal, 2011; Warr, 2002).

As a multifaceted concept, the quality of the work environment is further subdivided into three sub-themes. The first sub-theme discusses the complex nature of the aged care job or the well-being impacts of the essentially physical, confronting 'body work' personal care (Twigg, 2000; 2004, 2006; Twigg et al., 2011), and the emotional labour intrapersonal aspects of aged care work (Hochschild, 1983). In this sub-theme, are the spiritual aspects of the aged care job which include its characterisations as a calling or vocation (Raatikainen, 1997). Perceiving work as a calling is considered a key pathway to enhancing work-related well-being (Duffy et al., 2018). The second sub-theme discusses managerial practices around work scheduling, job control, manager and/or supervisor support, workloads, resources, occupational health and safety, and pay (Boxall & Macky, 2014; Braedley et al., 2018; Guest, 2017; Grawitch, et al., 2007; Lawson et al.,2009). Finally, the third sub-theme discusses how workplace relations between participants, managers, co-workers and residents' impact on psychological, social and emotional well-being (Simon et al., 2010). The aim of this discussion

chapter, therefore, is to reflect on the main results of this thesis and put them into a broader theoretical perspective of well-being and the work environment.

Workplace well-being

The meaning of well-being remains elusive and contested (Hone et al., 2014) but there is also a growing convergence on several constructs that constitute workplace well-being that were reflected in how this study's participants described their well-being. Previous studies have argued that workplace well-being cannot be separated from life experiences outside work because a person's physical, social, psychological and emotional workplace experiences have a spill-over effect into non-work domains (Danna & Griffin, 1999; De Simone, 2014a; Warr, 1999; Warr & Nielsen, 2018). Therefore, both individual and organisational factors impact care workers' well-being (De Simmone, 2014a; 2014b, 2015). Consistent with these views, the findings showed that the individual participants' pre-migration circumstances, including their migrant identities and migrant legal status (Kanengoni et al., 2018), were heavily implicated in how the participants 'felt and functioned' in the workplace (Aked et al., 2008; Fisher, 2014; Keeman et al., 2017). Consistent with previous studies, the participants' workplace well-being was influenced by different factors of 'the quality of the work environment' (Knudsen et al., 2011; Markey et al., 2015) such as ARC work demands and management practices around issues such as control over work and its flexibility (Wood & de Menezes, 2011); 'pay levels' (Baptiste, 2008; Macky & Boxall, 2008; Wood, 2008) and 'work-life balance' (Baptiste, 2008; Gröpel & Kuhl, 2009).

The participants' well-being was also impacted by the quality of relationships with their managers, co-workers, residents, and family relations of the residents (Clarke & Hill, 2012; Diener et al., 2010; Hone et al., 2015; Liang et al., 2013; Jarrad & Hudson, 2017; Roche et al., 2014; Wood & de Menezes, 2011; Schmidt & Diestel, 2014). The findings showed that well-being was characterised by physical, social, and psychological/ emotional experiences of work. As a result, in this study, well-being is defined as a multidimensional and heterogeneous construct that captures an employee's perception of the total quality of his/her physical, social, emotional experiences and functioning at work (Aked et al., 2009; Diener & Chan, 2011; Grant et al., 2007).

Migrant identity and workplace well-being

Frequently reflected in various forms of exclusion and inequitable treatment, migrant experiences provide a crucial window into the origins and institutionalization of precarity that generally underlines migrant identity and the lives of migrant workers (Paret, & Gleeson, 2016). The migrants' arrival in the host country is described as a "total" event (Mauss 1966) precisely because it requires;

> "the complete (re)construction of identity. After leaving their country of origin, migrants lose their social status, family, and social networks. In the receiving country, they find themselves without a history and without an image" (La Barbera, 2015, p.3).

The theory of narrative identity argues that individuals construct their identity by integrating their diverse and conflicting life experiences into an evolving yet continuous narration that provides them with a sense of direction regarding their life trajectory (McAdams, 2018; Somers, 1994). In this respect, the findings of this study show that the process of identity construction of migrants cannot be understood only with reference to migrants' subjective meanings of their individual experiences. It is important also to examine identity as a product of the labour market demands, migration policies, and citizenship regimes and the labour policy environment in so far as they generate precarious migrant lives (Pessar & Mahler 2003). The identity of the migrants, especially with regard to workplace precarity, cannot be separated from the influence of diverse economic and social contexts (Buckley et al., 2017; McDowell 2015).

In this study, the migrants' encounters with new experiences and encounters in New Zealand made them feel lost, alone, and no matter how hard they strove to become integrated, they felt that they were still strangers. They experienced the harsh reality of exclusion that is, ironically, in stark contrast with the idealized image of New Zealand as a place of abundant socio-economic opportunities - a reason that drove them to leave their country of origin. Their identity is therefore defined by their new position or condition of being 'in between,' or at the periphery, and in transit (La Barbera, 2015). Their lack of a sense of belonging was therefore a crucial step in the processes of the formation and identity reconstruction for the migrant care workers. In this study, belongingness emerged as a complex process for migrant care workers as it depended on whether they felt that the New Zealand labour market accepted or rejected them. The failure to secure jobs that they considered as qualified for, and other perceived discriminatory workplace practices represented denial by the host country to support the migrants' integration, which is important for their well-being. The temporary visas and lack of acceptable employability skills portray migrants as the other with huge implications for their integration and/or marginalisation. As previously discussed, migrant identity is a social construction that is shaped 'externally and internally' (Mead 1934[1974] p.164) by the migrant's largely poor individual pre-migration circumstances, host country restrictive migration and visa policies, everyday encounters and experiences with the host country's labour market requirements, workplace dynamics. All these combines to produce precariousness in the migrants' and a sense of lack of

belongingness in their lives leading to individual behaviours and actions that are tied to workplace well-being outcomes.

Previous research has observed that among other reasons, many skilled people migrate due to poverty and poor domestic labour market opportunities in relation to their qualifications and skills (Black et al., 2011; Sargeant & Tucker, 2009; Osorio, 2010; Wise, 2015; World Bank, 2011). In this study, the largely negative home social, economic and labour market circumstances that influenced the 23 participants' decision to immigrate to New Zealand provide a useful context that enables a nuanced understanding of the participants' reactions to workplace events and conditions of work that had significant well-being consequences. Several aspects that combine to build the migrant identities such as individual experiences of migrants, and after migration host country labour market and workplace experiences influenced workplace well-being in complex ways. The findings challenge Sjaastad's (1962) argument that migrants are completely 'free' agents that individually choose how best to achieve returns on their human capital and resources (Sjaastad, 1962).

First, the largely constrained home country socio-economic and labour market circumstances achieved to generate precarious and vulnerable migrant identities which in turn significantly influenced migrants to take up low wage jobs that are generally characterised by limited chances of job mobility and largely shunned by local-born employees (Anderson, 2010; Anderson & Rogaly, 2005; Castles & Miller, 2003; Creese & Wiebe, 2012; Kalleberg, 2000, 2009, 2011; Kalleberg et al., 2000; Krings, 2020; Lewis et al., 2015; MacKenzie & Forde, 2009; Martin, 2007; Moyce & Schenker, 2018; Piore, 1979; Standing, 2011; Waldinger & Lichter, 2003). Previous research has argued that work and economic opportunity are the biggest drivers for immigration (Bartram, 2010; Dean & Manzoni, 2012; Glaesser & Cooper, 2014; Schenker, 2010). In this study, for many participants, emigration was financed on borrowings from various sources, and this created undue pressure on them to repay the loans. The circumstances surrounding the financing of their migration journey and resettlement costs shows that a process as expensive and life-defining as migration is rarely undertaken as an individual act and is shaped by complex social interactions within kinship networks and beyond (Deshingkar, 2018, p.2638; see also Lindquist et al., 2012). The home socio-economic pressures were part of the reason the participants were open to taking up any job that could help them relieve them of that pressure.

Additionally, the need to secure their economic livelihood in a new country of residence combined with their lack of locally recognised qualifications (Ebner & Helbling, 2016)

and local labour market experience, as well as lacking a strong ‘social support network’ (Hadjar & Backes, 2013), effectively placed the participants in a position of taking up jobs with low entry barriers characterised by poor conditions of work (Andall, 2007). These jobs are commonly referred to in the literature as ‘3-D jobs' which stands for ‘dull, dangerous and dirty’ (Paraschivescu, 2012) or dirty ‘dangerous ‘and ' and ‘difficult or degrading' (Syed, 2013) or ‘dangerous, dirty and dull’ (Knight, 2014). One of the reasons for the paradoxical nature of these generally high-qualified immigrants being employed in the sometimes 3D employment is that they were socio-economically driven. The ‘push and pull’ (Piore, 1979; Winbush & Selby, 2015) of the socio-economic conditions in the country of origin and the destination country – New Zealand – including the range of New Zealand employment opportunities, contributed to the migrants taking up ARC work. They wanted to improve their family’s living standards and the New Zealand currency allowed them to earn more than what they were earning in their previous jobs in their country of origin (Favell 2008). These findings resonate with other studies that argue that migrants take up low-wage, low-skilled jobs, partly due to the migrants’ necessity to earn (Parutis, 2011; Piore, 1979). It has, however, been argued that underemployment has negative outcomes for well-being (Hobson & Bede, 2015; Feldman, 1996; Friedland & Price, 2003; Norton-Erichsen, 2015).

At the same time, there were also other reasons for taking up the less attractive ARC work beyond the participants’ desire to earn money once they arrived in New Zealand. The participants’ previous qualifications and experiences did not match the requirements of the New Zealand labour market. For example, in the case of the overseas qualified nurses, they had to meet local registration requirements to practice in New Zealand. Without registration and needing to secure their economic livelihood in New Zealand, they ended up taking jobs that were not commensurate with their previous training and qualifications. Extant research has noted that migrants experience significant challenges securing preferred jobs due to their lack of appropriate qualifications, local working experience and skills, lack of local cultural knowledge, limited English oral communication and other soft skills (Borjas, 1985; Chen et al., 2010; Chiswick, 1978; Colic-Peisker & Tilbury, 2006; Curries, 2007; Datta et al., 2007; Esses & Dietz, 2007; Fitzgerald, 2007; Holgate, 2005; Piore, 1979; MacKenzie & Forde, 2007; Mpofu & Hocking, 2013; Siar, 2013).

Previous studies have also noted challenges surrounding the recognition of migrants’ overseas qualifications (Chapman & Iredale, 1993; Reid, 2012). As a result, most migrants experience underemployment in their new country of residence (Datta et al. 2007; Liversage, 2009) and are therefore disadvantaged in “producing the

instrumental goals of status, for example, higher level jobs..." (Hadjar & Backes, 2013, p.651). It is argued that "bad jobs can undermine health and well-being…" (Carre et al, 2012, p.1) whilst underemployment induces adverse mental health impacts equivalent to the stress associated with being unemployed (Dooley, 2003; Scott-Marshall, et al., 2007). The findings therefore show that the pressure from the home environment combined with the migrants' lack of, for example acceptable qualifications and local New Zealand working experience to generate within the participants a heavily constrained sense of agency (Collins & Bayliss,2020).

Consistent with prior studies on migrants, this study found that several participants considered care work as a labour market entry strategy or steppingstone into preferred jobs (Simonazzi, 2009). Ironically, global economic inequalities mean that a lot of migrants, including those with high educational qualifications and good social standing in their home countries, can earn more in such jobs in developed countries than would be the case even in their home country professional jobs (Massey et al., 1993; Ozyegin & Hondagneu-Sotelo, 2016). Some of the participants understood that their lack of New Zealand based work experience, or a lack of local registration requirements to practice in New Zealand, accounted for their failure to obtain nursing or managerial jobs equivalent to those they occupied before immigrating to New Zealand. However, others felt that the lack of 'New Zealand experience' was a cover for the actual reason which they believed had to do with their being foreign or belonging to a different race.

A closer analysis of the responses of several participants regarding why they had become aged care workers reflect their perception that racism had played a big part. For example, one participant disappointedly referred to her 'African qualifications' as not enough to land her a job commensurate with her qualifications to support herself and her family. The racial undertones in her response were unmistakable. The other participants strongly believed that had it not been for their foreign identity, they would have been in more respectable and better paying jobs. Several aspects of their migrant identities that defined the migrants as the 'outer-group' or 'outsider' were highlighted as primarily responsible for the migrants' failure to secure roles commensurate with their qualifications resulting in them taking up aged care jobs. Some of these identity markers include their foreign qualifications, their foreignness, their race and temporary visa holders. It can also be argued that the requirements for New Zealand experience and specific employability skills that migrants seem to lack reflect the segmentation and 'ethnicisation' of the labour market and its adverse impacts on the life prospects of the migrants who remain socially excluded and limited to certain niches – usually poorly paid jobs – in the labour market (Constable 2007; Deshingkar, 2019).

This reflects the role of perceived racism in the structural marginalisation of migrants in the host country. This structural marginalisation is also evident in the view of participants that arrived in New Zealand already qualified nurses that they were in aged care primarily because of the national labour market laws that did not recognise their qualifications, yet the labour market employed them on account of their previous nursing qualifications. The credentialing of the migrants' foreign qualifications can therefore be characterised as state sponsored structural marginalisation of migrants.

Most of the participants perceived discrimination in the recruitment process. Whilst admitting that employing migrants on temporary visa was not an attractive quality for employers since the visas had to be renewed at expiry, most of the participants believed that their failure to secure jobs that they were trained in was due to discrimination practices in the New Zealand labour market. This finding resonates with studies which, for example, found that "minority candidates were significantly less successful when applying for jobs than 'white natives' with identical qualification" (Weichselbaumer, 2019, p.237). This finding also echoes past research which found that migrant workers may have no option but to take up low paying jobs partly because of their migrant legal status and discrimination (ILO, 2011; Ramírez & Chan 2020; van Hooren, 2012). In this regard, Standing (2011) describes migrants as "grinners who welcome precariat jobs, and groaners, obliged to take them in the absence of alternatives" (p.59).

Another analytical approach could easily restrict analysis of the well-being-work experiences interface to factors within the individual aged care facilities such as management practices and poor work conditions. This thesis argues that such an analytical approach notwithstanding its advantages is defeatist because it ignores the larger environment within which these conditions are occurring. It is important therefore to situate the conditions that the migrant care workers encountered in the New Zealand labour market - specifically in the aged care settings - that impacted their well-being within the business policy context which they occur. As argued by Thapan

> 'migration is not a free-floating, uncontrollable process prompted and carried forward by the personal needs and aspirations of individuals. Apart from societal structures, the state regulates the process from the start; it controls and engenders the channelling of immigrants into the different and limited work options' (2005,p.29).

As such, this study has responded to Paret & Gleeson's (2016) call to study the connections between migration and precarity to understand the globalised systems of

production to this end, the extensive literature review of the concept of neoliberalism in Chapter 3 suggested that the work conditions that migrants encounter in the host country are consistent with the fundamental values of a neoliberal business model which have effectively created what Standing (2011) calls 'the precariat'. The nature of work and the workplace environment are changing under the pressures of neoliberal capitalism creating precarious work (Lambert & Herod, 2016). Low earnings, poor access to social and regulatory protections, and a compromised ability to shape one's working arrangements are all hallmarks of precarious work (Elliot, 2013).

Secondly, the participants' aged care roles and day-to-day workplace interactions, their pre-migration circumstances, and their migrant identities (characterised by temporary work visa, temporary visa status, lack of local qualifications, being a foreigner), combined to effectively shape how they reacted to workplace challenges. These workplace challenges included abuse from residents, perceived unfair rostering, and perceived discrimination from some of their managers. As target earners (Piore, 1979) spurred by poor home country socio-economic conditions to immigrate, and aiming to maximise their earnings, they 'agreed' to work unhealthy long hours and other difficult working conditions (Orrenius & Zavodny, 2013). Several aspects of their migrant identities, for example being holders of temporary work visas and belonging to a different race from that of their managers contributed to the migrants' lack of confidence in voicing concerns about poor working conditions regardless of the toll on their well-being (Ronda-Perez et al., 2012). In this respect, voicing concerns about working conditions was one of the actions that they perceived could strain their relationships with managers. These managers were also important to the migrant because they considered their support critical to their continued stay in New Zealand.

The migrant characteristics did not only cause several participants to live with the fear of losing their jobs but also, feelings of vulnerability to employer and patient abuse. This has a direct impact on their well-being, from the harm associated with long hours and difficult conditions, to tolerating abuse that impacts them both physically and mentally. From a well-being perspective, it is argued that living with the fear and anxiety associated with losing one's livelihood is emotionally draining (Ewing, 2007). Additionally, without a job, there are no financial remittances to the home country to address the care deficit they created by immigrating to New Zealand. As argued earlier, one of the motivations for migrants taking low-skilled jobs is that employment is required to gain remittance funds (Fihel et al. 2006; Helinska-Hughes et al., 2009).

Consistent with Hart et al.'s (2019) studies, some of the participants were at pains to please their managers either for more shifts or as insurance for the support of the managers at the time of visa renewal. Past studies have also argued that the status of being a vulnerable immigrant working in 'precarious employment' (Valentine, 2010; Kagan et al., 2011) contributes to "vulnerability to abusive employment relations'' (Anderson & Rogaly, 2005, pp.8-9) and fear of asserting one's work rights (Basok et al., 2014; Goldring & Landolt, 2010, 2013; Ronda-Perez et al., 2012; Turchick & Ariss, 2013). Although their rights were protected under the New Zealand Employment Relations Act 2000, several participants doubted the effectiveness of New Zealand law to protect their rights as migrants. Previous studies corroborate the migrants' concerns by noting that the major statutory protections under the Employment Relations Act 2000 have not been accompanied by effective monitoring and enforcement – further exposing vulnerable workers to some unscrupulous employers (Anderson, 2014).

Quality of the work environment and well-being

Although participants experienced well-being at work in different ways, this thesis found that workplace well-being was greatly influenced by many aspects of the 'quality of the work environment' (Markey et al., 2012, 2015; OECD, 2017) as well as multiple challenges involved in working with residents at the end of life (Funk et al., 2014). As indicated earlier on, the quality of the work environment is a multi-faceted concept that encompasses the psychosocial aspects of work, such as experiences of work, job satisfaction and stress, and their impacts on well-being (Hvid & Hasle, 2003; Markey et al., 2015). Some environments are typecast as 'toxic' and others, 'conducive' (Kyko, 2005). In the following sections of this chapter, the discussion will focus on one of the three sub-themes under the major theme of 'quality of the work environment.' The first sub-theme discusses the nature of aged care work or the well-being impacts of the essentially physical, confronting 'body work' personal care (Twigg, 2000; 2004, 2006; Twigg et al., 2011).

The complex nature of aged care work and well-being

It is argued that job type, including the specific details and nature of the associated responsibilities, can result in either high or low levels of physical well-being (Hadgraft et al., 2016; Wood, 2008). In this study, all the participants experienced various degrees of difficulty with performing the essentially physical and dirty aspects of care work. In this regard, five factors related to the physical nature of ARC work account for the participants' largely negative experiences with their participation in residential care.

The first factor is the physical characteristics of aged care. Although a few participants identified positive health impacts of doing physical work, the majority experienced

extreme physical discomfort from working in a physically demanding environment (Hugo, 2009; Segal & Bolton, 2009). Additionally, even those who considered care work rewarding because it was a calling, could not help feeling overwhelmed by the physical and emotional aspects of care work (Farr-Wharton & Shearman, 2017; Montague, et al., 2015). Several participants complained about fatigue and body pain due to the physical aspects of aged care work. Although this fatigue could have been a result of the multiple jobs that were held by the participants, this finding is also consistent with aged care research that established the link between musculoskeletal conditions, such as back pain amongst nursing and care staff and physical job factors (Engkvist et al., 1998; Capponecchia et al., 2020). These negative physical well-being impacts of care work were compounded by other factors that will be discussed later, such as work overload, understaffing, lack of job control, shortage of time and care speed-ups.

The second stressful factor related to the nature of the care job is the heightened fear of occupationally acquired infections which had significant psychological outcomes of poor well-being, such as job-related anxiety and emotional fatigue (Geiger-Brown, 2010; De Jonge & Schaufeli, 1998; Schaufeli et al., 2014; Twigg, 2000, 2004). As argued by Huang et al. (2012), “much of what characterises care work is ‘hands on’ bodily work, involving a relationship between the body being cared for and the body that provides the care” (p.197). As ‘real body work’, care work involves the dirty work of ‘managing’ the ‘abject body’ (Cohen, 2011; Kristeva, 2007; Twigg, 2004; Twigg et al., 2011) which risks exposure to infectious bodily fluids of the residents (Twigg et al., 2011).

Compounding the migrant care workers’ anxieties about contracting infections as well as the lack of confidence in providing personal care to residents who had bed sores and other complicated personal care needs, was the perception of inadequate training. Most of the participants expressed high levels of mental distress associated with a lack of confidence to appropriately provide care to their residents as well as how to protect themselves during personal care. Extant studies argue that training is key to employee satisfaction including physical and mental well-being (Burton, 2010; Clarke & Hill, 2012; Rao & Clarke, 2010; Suresh et al., 2013; West et al., 2006).

Thirdly, and consistent with previous studies, several participants, especially those without prior nurse training, were overwhelmed by the bodily excretions of residents which they found dirty and revolting (Twigg et al., 2011). Realistically, care work is about meeting the physical, psychological, emotional, and developmental needs of residents whose bodies, often are in a condition that they should not be (for example,

being wet and smelling bad (England, et al., 2002; Isaksen, 2002a, 2002b; Ostaszkiewicz, 2017; Standing, 2001). In providing personal cares, aged care workers cannot avoid coming into contact with the generally 'disagreeable and unpleasant' (Isaksen, 2002a) "secretions, sights and old person smells" that linger in residents' living facilities (Aging Care, 2020, n.p.). Consistent with previous literature, some of the participants' culturally informed interpretation of body waste resulted in the urge to physically, socially, and emotionally detach from the aged care job setting (Isaksen, 2002a, 2002b). It can be argued that such reactions are antithetical to characterisations of ideal care as physically, socially and emotionally relational (Dahle 2005a, 2005b; Dyer et al., 2008; Isaksen, 2005). Of more significance to well-being is that these feelings of detachment existed side-by-side with the moral guilt of knowing that it was not ethical to feel that way towards their highly dependent residents.

Fourthly, participants experienced tension and frustration with the aged care job tasks, partly because of how they felt about privacy while performing care and how they felt about the actual appearance of the nude bodies of their elderly residents. This tension was mostly expressed by the participants that had no previous nurse training before they became aged care workers in New Zealand. Most of them cringed and winced at the appearance of the older bodies of their residents. Previous studies have noted that healthcare workers are often discomfited by the old residents' 'deformed and wrinkled' bodies (Isaksen, 2002a, 2002b; Twigg, 1997; Martin & Twigg, 2018). At another level, some participants felt that the invasive nature of personal care which exposed them to nudity of residents put them in positions of violating the privacy and dignity of their residents (Ostaszkiewicz et al., 2016; Ostaszkiewicz, 2017). Several participants were therefore especially concerned about the personal care task of resident toileting. Previous studies have argued that the 'intimate labour' (Boris & Parrenas, 2010) of elder care or 'body work' (Twigg et al., 2011) "…that focuses directly on the bodies of others" (Twigg et al., 2011, p.173) is "…often ambivalent work that may violate the norms of the management of the body, particularly in terms of touch, smell or sight" (Twigg et al., 2011, p.172). These findings therefore confirm that different cultural interpretations of an ageing body can cause difficult "existential, social, and cultural problems" for both the care workers and recipients of care (Isaksen, 2000a, p.792).

The significant discomforts that were experienced by participants with the appearance and touching of elderly residents' bodies have significant well-being implications. For example, most studies argue that there is a causal effect between employee well-being and job satisfaction in residential care (Aron, 2015; Engster, 2005; Kvist et al., 2014; Szecsenyi et al., 2011). As argued in Chapter Two, touch or physical contact is an

indispensable part of caregiving and therefore recommended for the physically and emotionally challenged or dying patients (Bonacini & Marzi, 2005; Chang, 2001; Pedrazza et al., 2015a, 2015b; Routasalo, 1999). More significantly to employee well-being is that positive feelings of ease during physical contact are associated with aspects that contribute to well-being, such as greater job satisfaction and reduced burnout (Pedrazza, et al., 2015a, 2015b). The fact that in this study, some participants cringed and winced at the sight and touch of the older bodies of their residents in addition to being spooked by the raw nature of the details of personal care, is testimony to the negative well-being impacts of the aged care job, especially the physical and dirty personal care.

Finally, although all the participants considered care work as meaningful work, some of them were not comfortable with the physical dirty aspects of the job, because in their view, these aspects reflected the low social status of the job (Nair & Healey, 2006; Olwig, 2018). Several participants were deeply aware that the aged care job was looked down upon by many of their friends, families, and social circles. Although occupational prestige is primarily determined by the educational or intellectual requirements of an occupation and not the amount of manual work in a job (Ostaszkiewicz et al., 2016, 2017; Treiman, 1977, 2013), many of the participants associated the physicality of aged care work with low social status. Even though no community can survive or prosper without manual labour (Khan, 2000), nonetheless, it is generally denigrated for its negative role in social identity building (Ashforth et al., 2008; Fullin & Reyneri, 2011; Khan, 2000). To establish one's overall social identity, it is argued that generally people use their job identity or occupational identity as a reference point (Ashforth et al., 2008; Hogg et al., 1995). Job type is therefore a source of social approval and group membership, especially if it can facilitate prestige or the social esteem that comes with being employed (Baran et al., 2012; Redfoot & Houser, 2005).

In this respect, it has also been observed that emigrating means contending with major cultural shifts in social identity, customs, food and language, including friends, colleagues, and family (Harrison et al., 2018). A significant aspect of the new immigrants with significant implications for how they adjust to the new environment is that the countries they migrate from may have no previous cultural, economic, or political relations with the receiving country (Fullin & Reyneri, 2011; Reyneri & Fullin, 2011). In this context, Harrison et al. (2018) have argued that in comparison to local employees, migrants are far more likely to experience difficulties reconciling their home and destination country identities in terms of "who I am becoming," "who I was," and

“who I will always be?” (p.4). As a result, they felt that their involvement in a manual job that is largely characterised with the handling of elderly resident excretions and the associated ‘social and physical taint’ (Clarke & Ravenswood 2019; Valtorta et al., 2019a, 2019b) could not confer them with the upward mobility that was one of the reasons that accounted for their emigration and the hope of getting well-paying jobs. It has been noted that performing such jobs leads to stigmatisation, dehumanisation and discrimination, which explains why some “people distance themselves from dirty workers and are not ready to help and support them” (Ashforth & Kreiner, 1999; Olwig, 2018; Terskova et al., 2019, p.767; see also Hughes, 1951; 1958). It is argued that negotiating this tension is a complex part of managing one’s identity (Meisenbach, 2008). In this respect, performance of dirty work challenged their identities (Solari, 2006; Tracy, 2005; Tracy et al., 2006). Several participants were therefore particularly concerned about the physical and social taint associated with caregiving as a job and expressed individual disgrace, shame, and embarrassment at being aged care workers. Past research has identified non-disclosure, “deliberate concealment, evasion or misspecification of the role” (Bove & Pervan, 2013, p.261) or ‘information control’ as common stigmatised labour practices (Goffman, 1963). In this respect, a few participants hid the identity of their job from their friends and lived with not only the shame of being aged care workers, but the guilt of lying, coupled with the fear of being found out (Carling, 2008). Shame is an emotion typically common among people who perform ‘dirty’ work (Rivera & Tracy, 2014).

The participants’ experiences of tension and discomfort at doing the largely physical dirty aspects of care work as well as being aged care workers are understandable when considered from Anttonen & Rasanen’s (2009) view that, “Well-being at work refers to the experience of the worker that is influenced by … how meaningful and rewarding a person finds work ...” (p.17). It could be argued that it is difficult to find work ‘rewarding’ and meaningful if it is societally stigmatised. As a result, some participants remained deeply conflicted and ambivalent about their aged care position as it signified ‘social downgrading’ (Yu, 2016). This ambivalence contradicts Piore’s (1979) seminal work on migrant workers where he describes migrants as ‘target earners’, in that their primary aspirations are to return home after saving enough to pay for a house or pursue other social and economic goals. On one hand, Piore’s thesis on the motivation of migrant workers is not entirely irrelevant, because it sheds some light on why and how this study’s participants endured aged care working conditions that had they been in their home countries, they would have considered beneath their dignity to perform. Piore’s views are further corroborated by Ronda-Pérez et al.’s (2012) response to Olesen et al.’s (2011) study, which found that non-Western

immigrant cleaners reported higher satisfaction with their psychosocial work environment compared to their local-born colleagues. Ronda-Pérez et al. (2012) surmised migrants reporting higher satisfaction was possibly because they might have had lower expectations of their working environment.

On the other hand, the problem with Piore's (1979) seminal work is that it characterises migration and work as purely an economic activity stripped of its other social identity formation significance. Piore's thesis is therefore problematic because the participants – judging by the permanent residence and visa extension applications – had no desire to return to their country of origin and were determined to make New Zealand their new permanent home. In this respect, it is argued that human migration is more than about seeking a job and encompasses something that can be a home or ''an emotional environment, a culture, a geographical location, a political system, a historical time and place, or a combination of all the above" (Tucker, 1994, p.184). Migration is therefore profoundly a home-searching experience (Kochan, 2016; Tucker, 1994). The findings of this study support this latter argument, in that the participants were interested in forming positive identity relationships with their job which in turn made their considerations about jobs in the context of social status, dignity of the job, dignity of self and personal identity important to their well-being (Sison, et al., 2016). The negative social well-being implications of a low status aged care job were therefore immense for some participants. They perceived that doing dirty personal care tasks did not contribute to their goals of societal recognition and social approval, nor did it confer them with the social prestige or external goods of recognition that were important to their social and psychological well-being (Karlsson & Gunnarsson, 2018; Twigg, 2006).

Low status and male care workers' well-being

Although all the participants' social and psychological well-being was somewhat affected by the social standing of the aged care job or its lack of prestige, these negative impacts were more pronounced with male participants than their female colleagues. The low social status image of aged care work had significant ramifications for how the male participants perceived themselves, not only as men but as masculine human beings. All the male participants', including – ironically – those who arrived in New Zealand already qualified as nurses, expressed regret about being care workers, partly based on their understanding that aged care work and the requirements for caring for other people's social and care needs were suited to the natural deportment of women. It has already been established that in most cultures, aged care work is associated with femininity (Pease, 2017; Ravenswood & Harris, 2016; Simpson, 2004).

As a result, globally, it is female-dominated work (Isaksen, 2002b). Although they were qualified nurses, they had not lost sight of the fact that the nursing profession has a long tradition of being associated with female participation. These findings therefore echo previous studies that found that most of the men in occupations with a higher preponderance of females are not 'active seekers' but 'passive finders' because ordinarily men are not enthused about doing female-dominated work (Hussein & Christensen, 2017; Simpson; 2005; Williams,1993; Williams & Villemez, 1993). Aged care was a passive choice for most migrants, but especially the males who generally considered it not such a 'manly' job to do. Their current situation was in their view worse because aged care workers occupied a lower position in social prestige compared to nursing. The results of this study suggest that perceived external prestige of the job augments employees' self-concept and by extension, their social and psychological well-being (Ashforth & Mael, 1989).

As a result, all the male participants experienced a loss of social status arising from doing a job that is pejoratively associated with women and 'aesthetic labour' (Morini, 2007) where emotional labour is not silenced (Hamman & Putnam, 2008). These aspects of care work threaten masculine dignity (England et al., 2002; Isaksen, 2000; Morini, 2007; Ochsenfeld, 2014; Twigg,1999) which explains why in a previous study, poor unemployed young men in some European countries preferred unemployment to employment as care workers (Isaksen's (2002a). They did not want to do 'women's work' as that risked being perceived as 'weak' and not 'real' men (Isaksen, 2002a, p.139). The manual and menial female-dominated low level aged care job was therefore a significant affront to their gendered social identity which caused significant disorientation due to the intense weight of the shame of failing to maintain 'masculine hegemony' (Budgeon, 2014; Connell, 1987, 1995, 2000; Schippers, 2007). Those who deviate from gender norms experience a 'backlash effect' and are often judged as inadequate (Kark & Eagly, 2010; Rudman & Phelan, 2008).

Spirituality, aged care work and well-being

Notwithstanding this reality of the impacts of bad jobs on individual dignity, workplaces are also sites where dignity can be achieved and enriched (Hodson, 2001; Sayer, 2007, 2011). It is argued that people who do dirty tainted work, must contend with the associated negative psychological and social impacts, especially to their dignity and sense of self-worth (Deery et al., 2019). Consistent with previous studies, to counteract the social and physical taint of their aged care job, several participants emphasised aspects of the job that were in harmony with their spirituality. As argued by Hood-Morris (1996), spiritual health includes transcendent and existential features pertaining

to an individual's relationships with the self, others and a higher being, coupled with interactions with one's environment. Existential well-being refers to the individual's sense of purpose in life and life satisfaction, whilst religious well-being, includes the individual's belief in God or a spiritual being (Ellison & Smith, 1991). Therefore, the participants dealt with both the pain of occupational downgrading, and the poor aged care work conditions by reframing the value and meaning of aged care (Ashforth & Kreiner, 1999; Ostaszkiewicz, et al., 2016).

The "search for meaning" is often cited as a reason for quitting a job to lead a more spiritually enriching life (Naylor et al., 1996; Burack 1999). Employees ask themselves questions such as 'Why am I doing this work? What is the meaning of the work I am doing? Where does this lead me to? Is there a reason for my existence and the organization's? (Houghton et al., 2016). In the case of this study, the aged care job was explained from a perspective of sacrifice to achieve the good of the extended family. For example, some of the participants described their emigration to New Zealand and taking up ARC work not necessarily as a career choice, but more as a by-product of the origin country's bleak socio-economic and job realities. ARC was therefore a form of sacrifice for the larger family good (Yu, 2016; Fairlie, 2011a, 2011b) that was providing opportunities for their children to grow up in a country with better socio-economic prospects than their own job trajectories (Clarke & Ravenswood, 2019; Doyle & Timonen, 2010a). However, the intimate nature of care work resulted in participants developing "a very strong sense of duty towards their residents" (Timonen & Dyle, 2010a, p.26). This research found that the relational nature of care inherent in actions central to helping residents who needed their help or doing what outsiders perceive as 'thankless dirty work' (Dutton et al., 2010; Hodson, 2001; Stacey, 2005; Bailey & Madden, 2016) contributed to the participants' experiences of a sense of fulfilment, purpose, and dignity in the workplace. The findings also confirm previous findings about the importance of meaningful work to well-being, especially if the employee perceives authenticity between work and life purpose beyond personal needs (Bailey & Madden, 2015). In this study the participants were able to frame their work as honourable, despite poor terms and conditions of work (Ashforth & Kreiner, 1999). This re-evaluation of dirty work is consistent with Frankl's (1959) argument, that a human being's quest for meaning and purpose in life remains a priority, even in the face of dire life circumstances.

These findings show that workers that do low paying, 'low level 'demeaning' 'dirty' work do not necessarily lose the agency to redefine or recast their job so that it becomes meaningful (Ashforth & Kreiner, 1999; Dutton et al., 2010). From a well-being

perspective, it is argued that the two enduring longings in human life are to enjoy what we do, and that what we do matters (Ryan & Deci, 2001). This view is reinforced by findings showing that employees value meaningfulness more than any other terms and conditions of work (Bailey & Madden, 2017).

The findings show that spirituality is a major aspect of the rationalisations that migrants use to deal with doing a socially stigmatised low-level aged care job. The rationalisations in turn enhance their well-being. Several participants explained how their spirituality was key in helping them to handle especially the confronting aspects of personal cares. Workplace spirituality encompasses aspects such as spiritual growth and advancement of the human experience, fulfilment of individual needs such as affiliation and achievement (Burack, 1999). Some of the participants described caring for the elderly patients as an act that could not be explained by using traditional lenses of monetary incentives and rewards. In this respect, a few participants described their job as a 'vocation or calling' (Bjerregaard, Haslam, Mewse et al., 2015; Bjerregaard, Haslam, Morton et al., 2015; King et al., 2012; Nelson & Folbre, 2006) or as a 'moral imperative to care' (Higgs & Gilleard, 2016). This perspective of care work made them to experience higher levels of job satisfaction. Despite the difficulties associated with aged care jobs, other participants nonetheless derived a lot of job satisfaction from the opportunity to provide care to residents that had limited abilities for self-care (King et al., 2013a, 2013b; Martin, 2007). Describing work as a "calling", suggests that the job engages individual on a spiritual level (Word, 2012). Individual spirituality has been found to be critical to the job satisfaction of hospice workers (Clark et al. 2007). Other studies have however established that being spiritual in and of itself does not increase satisfaction and argued that the fit between the person's spirituality and job is important to capture the benefits of spirituality in organizations (Word, 2012). This study found that employees that readily saw the connection between the aged care job tasks and transcendental spiritual aspects of life found satisfaction in their job (Ashmos & Duchon, 2000). Extant studies have argued that whilst some people may consider their work as merely a job they do for money, career achievement motives, or for status purposes, others view it as a 'calling' or 'vocation' in which the work is done for pro-social intentions or to contribute to a greater good (Dik & Duffy, 2009; Duffy and Dik, 2012; Dik, Eldrige, Steger & Duffy 2012; Elangovan, Pinder & McLean, 2010).

At the same time, it is important to note that although there are positive associations between a sense of calling and beneficial outcomes, it has also been established that a sense of calling can be a double-edged sword in that it creates vulnerabilities, commonly called "dark side" of calling (Bunderson & Thompson, 2009; Duffy,

Douglass, Autin, et al., 2016). From the perspective of long-term care, this means that whilst on one hand the sense of calling can make employees to identify with and find broader meaning and significance in carework, on the other hand, this might make them more likely to see their work as a moral duty, sacrifice pay, personal time, and comfort for their work, and to hold their carework to a higher standard. It is also argued that this sense of 'vocation' or ‘calling’ is often manipulated by managers to keep wages low (King & Meagher, 2009).

Religious beliefs were at the same time ironically a source of stress for several participants especially with regard to the way the deaths of elderly patients were handled in the aged care facilities. Some of the participants were disturbed by the patient management practices at individual aged care facilities that allowed relatives of the patients they were looking after to give ‘a do not resuscitate’ (DNR) order to the age care facility if their relative got into some cardiac arrest. In nursing literature, spirituality is an important aspect of holistic patient care (Buck, 2006; Liu, & Robertson, 2011). Although it could be argued that individuals have a right to establish a DNR order and that some patients consider a DNR as part of caring, the fact remains that the DNR order contradicted their spiritual beliefs about who has the right to give life and death. Several participants felt that their employers treated deaths of patients in a too ordinary way. Therefore, the participants struggled with continuously negotiating ‘between the institutionalized and the private and the institutionalized arenas in their care for their patients as all of them came from countries where this care is family-based. They also struggled to negotiate what they believed to be a secularized aged care delivery environment and their religious beliefs about what was ideal care for elderly patients (Lavik et al., 2020). It is argued that;

> “As in life, so in death: we find global patterns, and we find both enduring and emerging variations, and these variations are by nation as well as by the more conventional sociological variables of gender, class, ethnicity and religion. (Walter, 2012, p. 139).

These findings show that care workers used their own internalized religion as a sense of self-relief when they found themselves experiencing tension between their own religious beliefs and what they interpreted as secularized ways of caring for the elderly patients. In this respect, it can be argued that although ‘the intersection between religiosity, nursing, and health is well established’ (Page et al., 2020), at the same time, these interconnections can be complicated by the care workers’ socio-cultural perspectives of death and caring for the elderly. Therefore, for several participants,

spirituality played a huge role in helping them to negotiate events such as death in their workplaces or loneliness and suffering of their patients.

Emotional labour in aged care work and well-being

The emotional labour intrapersonal aspects of aged care work also impacted on the workplace well-being of the participants in varied ways (Delgado et al., 2017; Folbre, 2006; James, 1992; Johnson, 2015; Smith, 2012; Stack, 2005). On one hand, the emotional labour content of ARC work in the form of social and familial bonds that naturally developed between the care workers and their residents provided social benefits to the participants that enhanced their social and psychological well-being (Stack, 2005). On the other hand, and consistent with prior studies, the intimate nature of personal cares which exposed them to lonely, suffering and dying patients resulted in care workers experiencing emotional exhaustion (Addati et al., 2018; Anderson & Gaugler, 2007; Dyer et al., 2008; Erickson & Grove, 2007, 2008; Hayward & Tuckey, 2011; ILO, 2018; Hochschild, 1983; Marcella & Kelley, 2015; Maslach & Leiter, 2016; McVicar, 2003; Portoghese et al., 2014; Ruotsalainen et al., 2014). In this study, several participants, especially those that had no previous nursing experience, became over-involved in the lives of their residents and could not show "detached concern" (Lampert & Glaser, 2018, p.129) which resulted in the blurring of the line between resident as the patient, and care workers as the professionals. This ultimately made the grief experience associated with the resident death more intense (Anderson & Gaugler, 2007; Durall, 2011).

For several participants, the caring relationships that they had successfully cultivated with their residents became double-edged swords because they [participants] struggled to resolve their own feelings of grief (Banerjee & Rewegan, 2017). In this respect, a concerning issue in relation to their well-being is that those who encountered death of their residents did not know how to deal with the ensuing overwhelming sense of sadness and emptiness (Anderson, 2008; Anderson & Gaugler, 2007). This situation was worsened by some aged care facilities that nurtured an "organizational culture of denial and silence around death and dying" in residential care (Marcella & Kelley, 2015, p.3) by not extending support to those who experienced such events. In the case of this study, this is not helped by the statistics that show that internationally, New Zealand has the highest number of reported deaths in ARC (38%) (Broad et al., 2013a, 2013b).

The participants interpreted this lack of support as effectively communicating to the participants that they were to self-manage their emotions, even though some of them lacked the necessary emotional management skills (Grandey, 2000). As a result, those

who needed emotional support desisted from seeking help for fear of being considered unfit for the emotional nature of their aged care roles (Moss & Moss, 2002; Van-Hein Wallace, 2009). For migrants to be judged unfit for care work is concerning, in light of the widely recorded labour market challenges they experience in securing their preferred jobs (Anderson, 2012; Atanackovic & Bourgeault, 2013; Cangiano & Shutes, 2010; Chiswick & Miller, 2009; Constant, 2014; Lowell et al., 2010; Timonen & Doyle, 2010b; Walsh & O'Shea, 2009, 2010). This left them not only vulnerable to emotional over-involvement and psychosocial distress (Kaasalainen et al., 2007; Stansfeld & Candy, 2006) but feeling isolated in the workplace. Consistent with Stacey's (2005) study, these findings show that the aged care facilities continue to take emotional labour for granted, which in turn causes them to overlook its emotional consequences, especially for their migrant workers who come into the workforce with cultural perspectives of death that may not be aligned with how aged care facilities handle their residents' deaths. Additionally, some care workers questioned their role in invading the privacy of the residents by performing intimate personal care of cleaning, showering and toileting the residents. As argued elsewhere, "Bathing and washing are private matters, commonly accomplished alone, in dedicated spaces within the home" (Twigg, 1999a, p.381). The inability to put on a professional care provider persona meant that some participants consistently struggled with the performance of this intimate personal care.

The other source of emotional stress emanated from time shortage and workload pressures that promoted an environment conducive for 'transactional relationships' (Kaasalainen, et al., 2007; Stansfeld & Candy, 2006) between the residents and the participants. Past research has noted that a combination of limited staff, heavy workload, high resident-to-care worker ratio, and the higher dependence of residents, inevitably leads to the normalisation and mechanisation of the rush to accomplish mostly tangible personal aged care tasks (De Bellis, 2006). In this respect, the 'care speed-ups' (Selberg, 2013) forced participants to focus more on the completion of mostly, the visible and readily identifiable tangible components of care; the 'physical labour of care' (James, 1992). However, this was not necessarily the most important form of care that their residents desired. Knowing that their residents expected more combined with their (care workers') inability to adequately provide both physical and especially interpersonal intangible care resulted in them experiencing significant 'emotional dissonance' (King, 2012). That is, the conflict between organisational care rationale or how care was to be delivered, and their individual care rationales as authentic individuals performing emotional labour (Ashforth & Humphrey, 1993; Hochschild, 1983; King, 2012). Due to the intimate interactions with the residents, the

participants had become more aware of how the residents greatly valued intangible interpersonal relations in addition to the physical care (Attree, 2010; Bowers at al., 2001a, 2001b; Walsh & Shutes, 2013a).

Several participants therefore experienced 'frustration' (King, 2012) and guilt for not meeting the residents' desired standards of care. Frustration is a negative emotion and may manifest in burn-out and depression (Mutkins et al. 2011), while guilt or "regret over wrong-doing" (Eisenberg, 2000, p.667) arises when an individual "feels that he or she has violated some expectation or norm" (Van Kleef et al., 2006) – only that these negative emotions of guilt were due to organisational factors beyond the participants' control.

Therefore, although the participants in this study were genuinely concerned about giving person-centred care to the residents, they nonetheless struggled to reconcile their personal and cultural understanding of quality of care. Also, the rigid procedures and task-oriented care delivery system occurring within a context of constraints such as understaffing and other job resources, contributed to the problem. Consistent with previous findings by Moyle (2003) and Stockwell-Smith et al. (2011), it was found that the psychosocial needs of residents were not recognised, nor were they permitted to inhibit the completion of the participants' allocated tasks. As a result, when the participants were asked to identify factors that would make the biggest difference to their experience at work, the majority mentioned the time for social connectivity with residents.

Shift work, work-life balance, and well-being

The other work environment factor that impacted the participants' life is the shift and casual nature of ARC work or unscheduled working times. None of the participants could escape the negative impacts of shift work on their sleep patterns and the associated physical and mental well-being impacts (Warr, 1990). (Ferri et al., 2016; Liang et al., 2014; Lammers-van der Holst, 2016; Lowden, et al., 2010; Ferri et al., 2016). Additionally, consistent with extant studies, shift work impacted on work-life balance and physical and mental well-being in complex ways (Barnes-Farrell et al., 2008; Kelly et al., 2014). It is argued that work life balance (WLB) is key to the management of stress and/or burnout (De Bruin & Dupuis, 2004; Guest, 2002). On the one hand, several participants – mostly female – preferred shift work because it permitted spouses to study, work, and share childcare responsibilities (Batnitzky et al., 2009). Shift work also broke down some traditions which resulted in significant benefits for family bonding. For example, the men were able to bond well with their young children, something that would have been difficult to achieve in the country of origin

where tradition bestowed childcare responsibilities primarily to the women. The findings therefore also show that migration provides migrants with “opportunities to redefine roles and re-evaluate their perceptions of self, devoid of familial constraints and hierarchy” (Tapan, 2005, p.27). At the same time shift work also ironically caused the married participants to be extremely conflicted as they found it difficult to perform their culturally entrenched familial traditional roles such as cooking, laundry and general upkeep of the home. For the women migrant participants, it can therefore be argued that whilst migration provides them with opportunities to better their lives through employment, as well as allowing them to escape from cultural and social constraints, the findings of this study show that it is questionable whether the migrants completely break away from the binding patriarchal and traditional norms of their home countries.

It has been argued that whilst migrant workers make work-life balance for others possible, their own is often neglected (Dyer et al., 2011). Most migrants’ stay in a foreign country is predicated on being employed (Ackers, 2004; Dyer et al., 2011). They therefore take jobs that they would not ordinarily take in a home country environment. Therefore, the other group of participants experienced difficulties in developing healthy social and religious networks and other work life balance commitments due to pressure of irregular shifts which emerged as a significant source of frustration and stress. Research has shown that working nonstandard schedules leads to depressive symptoms via fatigue and disruption to biological systems, especially in the case of night work (Vogel et al., 2012; Bildt & Michelsen, 2002). Consistent with these previous studies, working shifts interfered with the smooth planning of family responsibilities and maintenance of life routines causing significant psychological and social stress (Iskra-Golec et al., 2016).

Extant research has also noted that shift work makes it harder for families to maintain healthy familial relationships that are vital to their well-being (Presser, 2003; Strazdins et al., 2004, 2006).The negative psychological well-being impacts of nonstandard work schedules on marriage and behaviour of parents employed in such jobs are well documented (Strazdins et al., 2004, 2006). In this respect, because of irregular shifts and on-call schedules, several participants struggled to find time to provide supervision of their children before and after school and sometimes were forced to rely on childcare services whose quality was sometimes questionable (Hsueh & Yoshikawa, 2007).

In the same vein it has been argued that those who are subjected shift and casual unstable low paid work often find that the long and/or unpredictable hours they must work make it difficult to schedule time with friends and family (Herod & Lambert, 2016). In this respect it has been argued that few events are as overwhelming as leaving

one's country to live in another country, as all major aspects of life are inevitably disturbed (Harrison et al., 2018; Shaffer et al., 2001). Finding time to meet other people outside work is important for migrants as they try to establish new identities and social support systems. Far away from their familiar home country environments, most migrant families experience challenges in achieving work-life balance (Dyer et al., 2011). In a new country and a new workplace, the reinforcement of one's identity that usually occurs through networking with friends and others with similar cultures is compromised (Alagaraja, 2020; Garcia et al., 2002; Swann et al., 1992). This makes the immigrants' family, relatives, and ethnic community crucial in providing the needed social support to immigrants, helping protect their psychological well-being (Finch & Vega, 2003; Noh & Kaspar, 2003). However, as was the case in this study, when most of the migrants' time is spent chasing shifts and agonising about uncertainty of work hours, or nursing fatigue due to the heavy workload, this means that they are also losing the opportunity to nurture social ties that are important for their social and psychological well-being.

It is argued that a strong social support system buffers the negative impacts of perceived discrimination especially for migrants operating in racialised work environments and suffering from racial discrimination based on both ethnicity and nationality (Colic-Peisker, 2009). Ultimately, social support for migrants impacts positively on psychological well-being (Fozdar & Torezani, 2008). It is also important to critically examine the concept of shift work using neoliberal lens. Shift work and casualisation of age care work are parallel a broader pattern of how work is organised in a neoliberal policy environment (ILO, 2012). As succinctly put by Lambert & Herod 'precarity is the dark side of 'neoliberalism's flexible work model' (p. 303).

Impact of management practices on workplace well-being

Aside from the impact of residential aged care work related factors to the well-being of the participants, the other critical factors within the broad theme of the quality of work environment that influenced their well-being are 'managerial practices' at the individual aged care facilities. Therefore, the following sections of this Chapter Seven, discuss the most cited managerial practices that impacted workplace well-being: including workload and staffing levels, work scheduling, work intensification, supervisor/manager support, and pay rates.

Workload, work design, staffing and workplace well-being

As previously discussed, several participants were overwhelmed by doing the essentially physical and dirty confronting aspects of personal care. These challenges were compounded by a heavy workload characterised by residents with increasingly

complex needs (Abdollahpour et al., 2012; Burrow et al., 2017). Through the JD–R model, it has been established that workload demands, in relation to resources, influence the employee well-being outcomes of job satisfaction and burnout (Bakker & Demerouti, 2014, 2017, 2018; Bakker et al., 2007, 2008). Notwithstanding a few participants that reported physical health benefits associated with physical work, most of the participants, and especially those without any nurse training, were overwhelmed by a heavy workload more frequently than not. This is consistent with previous findings where care workers without formal competence perceived higher workload and poorer sleep patterns and more stress than did their peers (Engström et al., 2011). The heavy workload combined with limited time and understaffing had precipitated the use of unsafe workplace practices, such as manually lifting patients instead of using time consuming sling belts and hoist machines which risked them being reprimanded by managers for not finishing their work within the allocated time.

Additionally, the participants, especially those that had previous nursing experience, often felt devalued and unrecognised. They felt that the rigid scheduling of personal care which they attributed to work overload combined with limited staffing per shift and limited time to complete personal care, did not allow them to exercise professional autonomy. The health effects of high demands and time constraints have been well established (Hochschild, 1997; Vanroelen et al., 2009). Previous studies have also noted that lack of job control reflected in rigid work schedules reduces staff ability to frame their work as dignified (Kadri, et al., 2018) and therefore negatively impacts employee health (Choi et al., 2008; Portoghese et al., 2014; Wheatly, 2017;). On the other hand, when care workers have a sense of autonomy or feel that they are appreciated and are also able to apply their skills in the job, they report greater job satisfaction (Jarrad & Hudson, 2017). It has also been argued that the downplaying of migrants' formal qualifications and experience and ultimately being treated as inexpert labour achieved through the rigid scheduling of tasks, is a deliberate measure adopted to control costs (Wrede, 2014).

Furthermore, workload and limited staffing in relation to the limited time to discharge personal care resulted in a work design method that was very unpopular with the participants: care speed-ups or work intensification (Boxall & Macky, 2014; Kalisch et al., 2006, 2014; Willis et al., 2015). In providing personal care, several participants therefore felt hurried due to a shortage of time and speed of care work, and this ultimately negatively affected their physical and mental well-being (Moen et al., 2011). As previously argued, meaningful work is a fundamental human need as it addresses the needs for autonomy and dignity (Terkel, 1975; Yeoman, 2014). Being able to

experience meaningful work is linked to higher levels of well-being (Arnold et al, 2007; Frankl; 1978, 1984). However, work intensification and shortage of time take away from work the structure that is supposed to enable employees to make meaningful connections with their work. In the case of this study, participants perceived that the conditions in their workplaces did not present them with ample opportunities to provide holistic care to their residents, which ultimately caused poor well-being in the form of emotional exhaustion (Selberg, 2013).

Remuneration and well-being

The other managerial/aged care owner-related practice which generated ambivalent if not conflicting responses from participants about its well-being impacts, is pay. Care work, as argued by Dyer et al. (2008), is characteristically low paid and performed in precarious conditions. Consistent with previous studies, few participants explained that caring for residents who needed their help compensated for poor conditions of work including pay (see for example, Alshmemri, et al., 2017; Duffy et al., 2013; England, 2005; George et al., 2017; King et al., 2013; Martin & King, 2007; Morgan et al., 2013; Rakovski & Price-Glynn, 2010; Ravenswood, 2011).

Notwithstanding this altruistic stance towards care work, as well as attempts at discounting the significance of pay to well-being, the reality is that low pay significantly affected their ability to meet their basic life needs. As a result, the same participants, like the rest of the participants, had more than one job which effectively contributed to the same participants struggling to experience a "satisfactory level of involvement or 'fit' between the multiple" (Gomes & Chukha, 2013, p.155) non-work social and religious roles (see Ravenswood & Harris, 2016). It is argued that host countries produce precariousness into the lives of migrants through the nature of employment (formal/informal), and the form of employment (temporary or permanent, part time or full time) and through its visa policies (; Goldring et al., 2009; Goldring & Landolt, 2013; Jokela, 2017).

Research has also noted that a combination of family-life pressures and financial concerns negatively impacts physical and mental health (Goel & Penman, 2015). Additionally, it has been argued that the less qualified long-term care workers are more prone to holding multiple jobs than their qualified colleagues (Cangiano et al., 2009; Eborall et al., 2010). However, in the case of this study, these findings show that even those qualified as care givers are prone to holding multiple jobs. For example, the only participant who could be argued to have been a qualified caregiver on account of holding New Zealand Levels 3 and 4 Health Care Certificates also held more than one job.

Whilst a few of the participants, as discussed in the preceding paragraphs, said, that caring for the residents compensated for poor conditions of work, including pay; the rest of the participants were unequivocally clear about the negative impact of low pay on their well-being. The latter group did not find anything to counteract the effect of low pay on their lives like the few participants discussed in the preceding paragraph. For the rest of the participants, the pay did not reflect the level of difficulties associated with aged care service delivery. Therefore, in addition to the poor experiences of work-life balance discussed above, this latter group of participants agonised about the social and physical repercussions of low pay in relation to heavy workloads and the confronting nature of ARC tasks. They also agonised about the social cost of separating from their children, spouse and colleagues for a low wage. Additionally, for those with previous nurse training, the stress of low pay was compounded by their belief that the New Zealand aged care facilities were benefitting immensely from their specialised nurse training skills and knowledge but used the excuse of a lack in CAP registration to pay them low pay rates in return. Previous studies have confirmed the existence of a positive correlation between a well-educated workforce and quality of residential care (Ouslander et al., 2010).

Previous research has noted that employers often experience significant benefits from hiring migrants who have higher qualifications and skillsets than the job requirements (Fellini et al., 2007, Rodriguez, 2004). Previous studies have recorded instances where organisations have profited from the myth of the migrant as a ‘good worker’ paying them a rate of pay that the local employees consider unattractive (MacKenzie & Forde, 2009). Consistent with previous studies, the participants’ migrant legal status placed them in a position of ‘accepting’ working long hours and other poor working conditions associated with aged care work (Basok et al., 2014; Berg, 2015; ILO, 2011; van Hooren, 2012).

As discussed in the literature, it is important to also provide a more critical context to some of these working conditions that the migrants experienced. A critical view of these conditions points at other layers of factors whose role is critical to an understanding of the nature of the work environment and its impact on workplace. These interactions between workplace well-being and employment experiences must be placed within a much larger environment even though no primary data was collected from an organisational or macro-environment perspective. This critical perspective is key in addressing the issues related to practice improvement. In making sense of these largely negative work environment factors, it is important to understand the larger context within which they were generated.as discussed in Chapter 3, most of the

largely negative work environment factors are a product of the neoliberal policy environment within which aged care organisations operate. The experiences that negatively impacted migrant care workers' well-being such as care-speed-ups, heavy workloads, shortage of incontinence pads for the elderly patients, poor wages which forced many to take up multiple jobs at the expense of their work-life balance; and lack of protective clothing, as well as minimal investment in their training, are all indicative of the far-reaching tentacles of neoliberalism. Among neoliberalism's central tenets, as was argued in Chapter Three, include the strategy of producing more with little, surplus value creation, profit maximisation, and a near worship of what is called the "self-regulating market" (Polanyi, 1944). In the context of aged care, it has resulted in reduced public expenditure on aged care services resulting in a real squeeze on public care. In the process, neoliberalism has created care regimes that are largely hostile to those who care for others (Pocock, 2005).

These fundamentals of neoliberalism are therefore inconsistent with a business model and work conditions and polices that can support higher levels of workplace well-being. The literature review provided a strong justification to adopt a critical perspective in analysing and understanding the raft of work environment factors that impact on the migrant care workers' well-being by arguing that aged care organisations and the work environment in the aged care sector do not exist in a vacuum, but a neoliberal context whose fundamental principles are largely antithetical to conditions of work that promote workplace well-being.

Perceived organisational support

Extant literature argues that the increasing adoption of teamwork as an effective approach to boost productivity, suggests that how migrant employees are treated by their managers, supervisors and peers will significantly influence their workplace experiences (Grant, 2007; Humphrey et al., 2007). The significance of social support to workplace well-being is also noted in theoretical models such as the JD-CS (Karasek & Theorell, 1990), ERI (Siegrist, 1996, 2002) and JD-R-S (Demerouti & Bakker, 2011). In this study several participants valued how their managers supported them, for example, by allowing them to work their preferred shifts, such as short, double, or long to accommodate their life outside work commitments. In respect to these aspects, one half of the participants felt that their managers were concerned for their well-being and gave examples of how they had actively adopted customised HR management strategies that recognised that, as migrants, their responsibilities and lives outside of work required greater flexibility in comparison to the life challenges of local national-born New Zealand care workers. This is partly because as migrants, they had lost the

social support system that they had relied on in their home countries, to reduce work-life balance tensions (Oludayo & Omonijo, 2020; Ungerson & Yeandle, 2005). Most of the participants therefore appreciated supportive management practices that minimised the negative impacts of shift work on their lives, such as job sharing, flexible working hours, flexible leave, short shifts, long shifts, double shifts, personal and parental leave (Department of Labour, 2003; Haar & Spell, 2004; Wood, 1999). Previous research has also acknowledged the importance of supervisor support in helping employees to better manage the interface between work and family (Kelly et al., 2014).

It is widely agreed that employees that perceive fair organisational processes tend to feel supported, which in turn results in less stress and positive well-being (Findler et al., 2007; Le et al., 2016). Because foreign workers operate in racialised workplaces, they generally experience social exclusion (Butcher et al., 2006; Galabuzi, 2006; McGregor, 2007), perceived discrimination (Stevens et al., 2012), and distributive injustice (Findler et al., 2007; Le et al., 2016), all of which affect especially their psychological and emotional well-being. In this respect, several participants were also happy that their managers did not discriminate against them in relation to shifts and workload allocation in comparison to their white colleagues. They also lauded the seriousness with which their managers swiftly responded to reported cases of sporadic abuse from some of their residents that had racial undertones. Consistent with previous studies, this study found that difficult residents are a big problem for aged care workers and low-level direct healthcare workers are more likely to experience abuse from residents than doctors or nurses (Pompei et al., 2015; Ravenswood et al., 2017). Several participants therefore praised some of their managers' 'open door policy' which gave them confidence to seek help when they needed it. Workplace well-being is often constructed as a product of communication or workplace interactions (Mikkola, 2019). A lack in open communication channels encourages employees to 'brush off' their workplace challenges to the detriment of their well-being (Haddon, 2018).

It is within this context of the well-being role of perceived organisation and supervisor support that the negative experiences of other participants with their managers provides important insights into the well-being-workplace experiences nexus. These latter participants felt that their managers downplayed the seriousness of their complaints about sporadic abuse from residents. When carers are physically abused by the residents and the managers show no concern, this communicates to employees that they must accept abuse as part of work and this results in perceptions of inadequate support, which in turn leads to psychological stress (Kadri et al., 2018). It is argued that employees who do not report abuse experience emotional stress (Lachs et

al., 2012) and lower poor job satisfaction (Lanctôt & Guay, 2014). Although this latter group of participants also perceived unfairness, injustice and discrimination and resident abuse, they decided against reporting to their managers after perceiving that the managers were disinterested in their concerns. Some studies argue that it is expected that the frequencies of unjust and hostile behaviour from managers including poor terms of work will be higher for migrants compared to native-born workers (Abrego, 2011). At the same time, it is argued that using their voice poses a serious challenge for migrants, because in expressing their problem it might not only elevate perception of visa continuation risk, but also risk further status decrement in the workplace (Howell et al., 2016). It is also argued that perceiving discrimination by members of a dominant group increases depression, anxiety, psychological distress, job stress and feelings of marginality and alienation among migrants (Dion et al., 1992; Schunck et al., 2015).

Impact of workplace relationships on well-being

Employee well-being, especially the aspect of social well-being is entrenched in a system of social relationships amongst employees, managers and co-workers (Kim, 2014; Kim et al., 2016) and family relations of residents. Additionally, good relationships between employees and managers lead to high levels of employee well-being (Baptiste, 2008). The migrants' relationships with aged care patients have already received significant attention in extant literature (Timonen & Doyle, 2010a). In this respect, relationships constitute the last aspect of the quality of the work environment that impacted on the participants' well-being (Timonen & Doyle, 2010a). Although a few participants had experiences of managers whom they perceived as not easily approachable and were discriminatory in various aspects of their workplace interactions, the majority engaged with managers that made them feel welcomed not only in the workplace but New Zealand. Informal conversations involving the managers inquiring about the migrants' non-work lives or inviting them to dinner or having tea breaks with participants were greatly valued by many participants. These actions made them feel confident that they were valued not only as workers but as human beings. It has been argued that migrants are generally vulnerable to stressors associated with living apart from their families and friends for long periods of time as well as challenges inherent to starting a new job and resettling in a new country (Bahn, 2013; 2015; Chiswick et al., 2008). The migrants' socio-cultural, economic, and emotional needs in a new country therefore extend beyond the confines of their job setting (Bahn, 2013; Ponizovsky & Ritsner, 2004). As a result, when they are in high-quality relationships with their managers, they may perceive increased support and attention that help them to feel better in the workplace.

The other workplace relationship with well-being implications is that of co-workers. All the participants also benefitted from the cordial and supportive relationships that existed between them and other co-workers. Wherever possible, they helped each other to do difficult personal cares or to handle difficult residents. These relationships were therefore important in making them feel as part of a team. The role of teamwork in improving employee well-being has already been noted (Kozlowski & Bell, 2003; Ogbonnaya et al., 2018). Previous research has noted that while care work generates difficult physical and psychological work experiences for all workers (Gao et al., 2015), for the migrants, these impacts are usually worsened by extra psychological work stressors such as experiences of discrimination from co-workers and residents (Nichols et al., 2015). Perceiving discrimination negatively affects how one views their place not only in the workplace but in the community as well (Schmitt & Branscombe, 2002). Contrary to studies by various authors including Amason et al., 1999; Ogbonna and Harris, 2006; Remennick, 2004; and Wang & Sangalang, 2005) that recorded difficult relations between immigrants and local born workers, in this study, none of the participants experienced discrimination from their local born New Zealand /white care colleagues.

The participants' relationships with their resident were also central to how they perceived their workplace well-being. A few of the participants experienced difficulties developing mutually respectful relationships with some other residents. Two incidents stand out. One relates to a participant who experienced challenges in getting some difficult residents to cooperate with her during personal cares but were very cooperative and friendly to her when she did the same duties in the company of a white care worker colleague. Previous studies have noted the role of similarities in cultural characteristics between the resident and the care worker as positive for good relations (Bourgeault et al., 2010). The other incident relates to a participant who experienced hurtful racial comments about smelling curry on her body. Past studies have also found that migrant workers regularly experience racist slurs in the workplace (Banerjee, 2008; Banerjee, et al., 2012). Those that encountered such negative experiences therefore felt bad about themselves and their roles as aged care workers in a foreign country. Past research has noted that migrant care workers experience prejudice and stereotyping from residents because of their cultural differences, from the dominant culture (Nichols et al., 2015).

Over time however, within the constraints of work overload pressures and understaffing that were conducive for largely transactional personal social interaction with their residents, several participants were nevertheless able to develop strong mutually

beneficial social and affectionate filial bonds with their residents (Bourgeault et al., 2010). As a result, and consistent with previous studies findings, several participants reflected on how the residents reminded them of their family relations in the country of origin (Walsh & Shutes, 2013b). Previous studies observed that due to the intimate nature of care work, most care workers eventually develop 'false kinship' (Cox & Narula, 2003) or quasi-familial relationships with their residents (Ayalon, 2009; Baldassar et al., 2017; Marcella & Kelley, 2015; Sims-Gould et al., 2010). Several participants revelled in their residents' affection and' friendliness and expressions of gratitude for looking after them. These positive reciprocal positive relationships in a cross-cultural work setting were a significant source of human interaction needs for the migrants that did not have a strong social support network outside work. Previous literature has argued that workers derive satisfaction and other psychological benefits associated with helping those who need help as well as from relationships of care (Ashley et al., 2010; Butler et al., 2012 Slocum-Gori et al., 2013).

Finally, the participants' well-being was impacted significantly by the way family relations of their residents treated them and their work. The participation of families in the lives of the residents was a significant source of both relief and distress for these participants. At the same time, some participants felt unappreciated because of the mistrust that was shown by the family relations of some of their residents who questioned their commitment to the provision of high-quality care to their relatives. The mistrust may be based on the prevalence of elder abuse by care workers in ARC facilities (World Health Organisation, 2002; Yon et al., 2019). Previous studies have already argued that caregiver depression is common when there are conflicts between care workers and the relatives of their residents (Chen eta l., 2007) staff burnout, and diminished job satisfaction (Abrahamson et al., 2009).

In the same vein, several participants could not understand why friends and relatives of some of their residents rarely visited the residents. The lonely residents appeared in their view to have been abandoned by their relatives and that pressured the participants into filling that filial gap. Various studies have demonstrated that families do not abandon their relatives in residential facilities but continue to directly provide body care; emotional support and physical resources to enhance the quality of care provided to their relatives (Bowers, 1988; Davies & Nolan 2006; Gaugler, 2005; Rowles & High, 1996; Zimmerman et al., 2013). To appreciate the participants' concerns in relation to their psychological and emotional well-being, it is important to note that although institutional aged care is increasingly being used in the participants' home countries, the uptake is not widespread. They therefore held cultural obligations toward

elder care that conceptualised care largely as a family responsibility (Boughtwood et al., 2011). Residential care, whilst not unknown to them, was still a cultural shock to many.

On the other hand, several participants greatly valued the support of family relations of their residents who during their visits took time to inquire about their welfare and thanked them for looking after them. Encountering grateful resident relatives was a significant source of job satisfaction. Job satisfaction is positively correlated with higher levels of employee well-being (Edvardsson et al., 2011). Previous studies have either presented family involvement in the residents' lives as a positive or negative development (Bauer & Nay, 2003). For example, they are described positively as 'health team members' (Montgomery, 1983) or 'partners in care' (Nolan & Dellasega, 1999, see also Harvath et al., 1994). In the same vein, Friedemann et al., (1997) calls them 'advocates and protectors' whilst Rubin & Shuttleworth (1983) positively labels them as 'resources' (see also Twigg & Atkin, 1994). Other studies have however identified the negative role the families' involvement in caregiving process. For example, they are described as 'a problem' (Safford, 1989), 'intruders' (Gubrium, 1991) as well as 'disrupters' (Tickle & Hull, 1995). In the same vein Twigg & Atkin (1994) identifies them as 'superseded carers'.

These findings confirm the importance of the relationship construct in understanding the meaningfulness of work and its implications for workplace well-being. Employees judge their work as meaningful if helps those in need, and when they do their work surrounded by supportive interpersonal relationships, (Bailey & Madden, 2015; Chalofsky, 2003). Those who experienced positive relationships with their co-workers, managers, residents and family relations of the residents looked forward to going to work. This contributed to an enhanced feeling of stable personal and family life.

Conclusion

This chapter has examined factors at the intersection of well-being and work experiences using the context of migrant care workers in the New Zealand aged care sector. The findings show that the participants' workplace well-being was influenced by an assortment of workplace experiences. In this respect the chapter has identified two broad thematic factors that impact the migrants' workplace well-being. The first is personal migration experiences, including migrant legal status and migrant identity. It was argued that the pressure of the home environment characterised by limited socio-economic opportunities combined with new labour market requirements in New Zealand resulted in the participants taking up ARC work regardless of the associated unattractive working conditions. Additionally, the temporary residence or visa status of

the participants at arrival in New Zealand injected vulnerability and precarity into the participants' lives with substantial impacts on their sense of security and overall workplace well-being. The second major thematic category of factors that impacted migrant care workers' well-being is 'quality of the work environment. This includes the nature of aged care, which is largely characterised by physical dirty aspects, as well as emotionally draining labour. The other workplace practices discussed include staffing, workload allocation, rostering, training, and manager support. Finally, workplace e well-being was significantly impacted by the quality of relationships between the participants and their managers, residents, co-workers and family relations of residents. Considering these issues, the next chapter will discuss how the research questions were addressed in this study.

Chapter 8 - Conclusion

The aim of this thesis was to examine the interface between well-being and workplace experiences in a context of migrant care workers. Extant studies have already noted the increased participation of migrants in the New Zealand ARC sector (Callister et al., 2014; Howe et al., 2019; McGregor, 2012, 2013; Ngocha-Chaderopa, 2014; Ngocha-Chaderopa & Boon, 2016). This study observed that despite this increased migrant participation in ARC, there is a dearth of studies investigating the migrant care workers' well-being in relation to their workplace experiences. As the final part of this thesis, this chapter starts with a summary of the key points/themes arising from the review of extant literature regarding the intersections between well-being and workplace experiences. This is followed by a discussion of how the following research questions were addressed:

1. How does migrant identity impact migrant care workers' well-being?
2. How do work conditions affect migrant care workers' well-being?
3. How do workplace relationships affect migrant care workers' well-being?

Finally, practical implications for policy and practice are provided, as well as recommendations for future research.

The process of examining the study questions was informed by a critical feminist ontological and epistemological understanding that reality is "subjective and differs from person to person" depending on individual experiences (see Creswell, 2007; 2009; Crotty, 1998; Guba & Lincoln, 1994, p. 110). If reality is individually constructed, this suggests that there are as many realities about how well-being and workplace experiences intersect as there are migrant care workers. Critical feminist epistemologies also consider the lived experiences of women and many other people whose voices are normally not heard as legitimate sources of knowledge (Campbell & Wasco, 2000). Therefore, in this study, workplace well-being was conceptualised as a product of the migrant care workers' individual migration experiences combined with the unique ways in which they interacted with the work environment (Burrow et al., 2017; Weale et al., 2019a, 2019b). Additionally, the ontological assumption behind the formulation of the research questions in a migrant care worker context was informed by an understanding that facts are culturally and historically located, and therefore subject to particular behaviours, attitudes, experiences, and interpretations of both the observer and the observed (O'Gorman & MacIntosh, 2014).This had epistemological implications for the knowledge-gathering process and spoke to not only the relevance but potency of the in-depth face-to-face, open-ended, semi-structured interviews in

addressing the study questions (Denzin & Lincoln 2011; DeVault & Gross, 2012). Additionally, as a migrant close to the issues but at the same time concerned about representing the views of the participants and not my own, researcher reflexivity assumed great importance to both the interviewing process and analysis of findings. This is because researcher reflexivity is part of the socially constructed nature of knowledge and representation of findings (Cunliffe, 2003).

Addressing the research questions

The Literature Review (Chapters Two and Three) established that work and the work environment play a critical role in well-being precisely because for many people, work is central to their sense of "self-worth, family esteem, identity and standing within the community (Black, 2008, p. 4, see also Danna & Griffin, 1999). In this respect, it was also noted that most of the conceptualisations of workplace well-being in extant management literature reflect a heavy influence of the WHO (1998) definitions of health and quality of life, in which three aspects stand out: physical, social, and emotional/ psychological needs of people (see also Danna & Griffin, 1999; De Simone, 2014a, 2014b; Dodge et al., 2012; Linton et al., 2016).

In this study, well-being refers to the work-related physical, psychological/emotional, social and spiritual aspects and their part in enabling or disenabling vulnerable migrants in precarious employment to physically, socially, psychologically/emotionally, and spiritually flourish and achieve their full potential for the benefit of themselves and their organisation. The reference to vulnerability and precariousness in this well-being definition links the definition to the crucial factor of migrant identity which refers to the lack of belongingness in the host country due to the combined influence of poor socio-economic circumstances that cause them to migrate, restrictive immigration regimes or visa requirements, unique host country's employment practices and workplace dynamics which together precarise migrant care workers' lives. Using social identity theory (McAreavey, 2017; Jenkin, 2000; 2014; Goffman, 1969) 'migrant identity is treated therefore as a social construction that is shaped 'externally and internally' (Mead 1934[1974] p.164) by the migrant's largely poor individual pre-migration circumstances, host country restrictive migration and visa policies, everyday encounters and experiences with the host country's labour market requirements, work place dynamics all which affect individual behaviours and actions that are tied to workplace well-being outcomes. Embedded within the concept of migrant identities are the pre-migration employee socio-economic circumstances leading to migration, possession of temporary visas as well as lack of appropriate or acceptable

qualifications and other labour market employability skills. All these factors facilitate the migrants' entry into ARC work. Several of these axes of precarity and vulnerability associated with migrant identity therefore interlock to effectively influence the way in which migrant care workers interacted with aspects of the quality of the environment that impact well-being (Bahn; 2015; Boese et al., 2016; Goldring & Landolt, 2011).

One of the key issues impacting the well-being and work experiences interface is the 'quality of the work environment'. The 'quality of the work environment' (Knudsen et al., 2011; Markey et al., 2012), includes social relationships and positive experiences at work (Fisher, 2014), and meaningful and rewarding work (Dik et al., 2013). As a multifaceted concept, the quality of the work environment also includes the following aspects:

- complex nature of ARC work as 'dirty body work' (Twigg et al., 2011) that is physically and emotionally demanding (Segal & Bolton, 2009), in addition to being poorly paid, highly feminised, and socially stigmatised (Clarke & Ravenswood, 2019; Manchha et al., 2020; Kaine & Ravenswood, 2014; Montague et al., 2015; Palmer & Eveline, 2012; Ravenswood & Douglas, 2017; Ravenswood & Harris, 2016).
- management practices in relation to supporting care workers in their roles (Guest, 2017; Redfoot & Houser, 2005) and;
- workplace relationships, especially between migrant care workers and managers, co-workers, residents, and residents' relations (Escrig-Pinol et al., 2019; Timonen & Doyle, 2010a, 2010b).

Embedded within the is concept of the quality of the work environment therefore are aspects such as the host country's restrictive migration and visa policies, everyday encounters and experiences with the host country's labour market requirements, and workplace dynamics, for example, workload, relationships with managers, co-workers, residents and relations of residents. The quality of the work environment' is part of the work-related factors that enable or disenable vulnerable migrants in precarious employment to physically, socially, psychologically/emotionally, and spiritually flourish and achieve their full potential for the benefit of themselves and their organisation as captured in this study's definition of workplace well-being. Well-being as mentioned previously, refers to work-related physical, psychological/emotional, social and spiritual aspects of the work environment and their part in enabling or disenabling vulnerable employees in precarious jobs to physically, socially, psychologically/emotionally, and spiritually flourish and achieve their full potential for the benefit of themselves and their

aspects of their care work.The literature review supports this study's conclusion that the nature of influence of the four factors (migrant identities; nature of ARC work; management practices; and workplace relationships) on the physical, social, psychological/emotional, and spiritual factors of well-being had to be understood within a specific policy and funding environment. Although migrants perceive mobility as a way to escape a limiting environment, migration policies as reflected in the use of temporary work permits seem to problematize migration as both a positive and destabilizing force that must be kept under control. In this regard, this representation of migration as a problem greatly influences the construction of precarious migrant identities which ultimately, for the migrants, generate a sense of marginality in the host country (Bourgeois & Friedkin 2001). Therefore, this thesis established that the legal status of migrants influences integration patterns in the labour market. Consequently, several participants experienced racial discrimination on several bases including their visa and migrant status. These experiences led them to accept low status aged care jobs that otherwise they would not have chosen.

Regarding the first research question of the study - "How does migrant status impact workplace well-being?"- the study concludes that the migrant identities including pre-migration individual circumstances, lack of acceptable labour market requirements, and temporary visa legal status are heavily implicated in the well-being of migrants in the host country workplace (Berg, 2016; Boese et al., 2016; Castles, 2000, 2010, 2011; Fudge, 2016; Piore, 1979; Reid et al., 2021). Consistent with previous studies, the migrants' constrained home country socio-economic background, which accounted for their migration and entry into low paying jobs such as aged care, and the migrant care worker identity, materialised in the form of migrant workers' precariousness in the labour market, at individual workplaces, and in life out of work (Awases et al., 2004; Castles & Kosack, 1973; Kevins & Lightman, 2019; van Hooren, 2012). The migrant status and the non-recognition of foreign credentials resulted in experiences of being "othered" (Huang et al., 2012; Siar, 2013). Therefore, the findings show that migration can be a negative well-being influence if it results in experiences of downward occupational mobility due to taking up low status employment such as aged care roles.

The migrant identity which is partly defined by holding a temporary visa impacts well-being by discouraging migrants from asserting their workplace rights. Several participants considered themselves highly dispensable in their job because they thought they could easily be replaced by other employees if they asserted their rights. Consistent with extant studies, the migrant workers' perceptions of insecurity associated with their temporary visa status resulted in the aged care facilities becoming

places where migrant care workers perceived a lot of pressure to maintain their employment contracts with their employers. This contributed to on-going pressure to deliver optimal care sometimes at great personal cost (Anderson & Anderson, 2014; Berg, 2016; Boese et al., 2016; Fudge, 2016; Mackenzie & Forde, 2009; Mares, 2016; Sorensen et al., 2019; Tham et al., 2016). Ultimately, these findings show that temporariness creates a work atmosphere in which the employees perceive that their employers' rights are expanded at the expense of their own (Dauvergne & Marsden, 2014).

The issues related to the migrant identities and legal visa status addressed in the preceding paragraphs, are intricately intertwined with issues central to the second research question: "How do the work conditions experienced by migrant care workers affect their well-being?" As discussed in the literature review and supported by the research findings, well-being was conceptualised as an amalgam of physical, social, spiritual, psychological and emotional aspects of the work. Figure 8.1 'Framework of Factors Affecting the Well-Being of Migrant Care Workers' identifies working conditions as one of the three aspects of the quality of the work environment that significantly impacts workplace well-being. In this regard, several conclusions can be drawn about the role of working conditions in the migrant care workers' levels of workplace well-being.

One of the significant conclusions regarding the working condition is that workplace well-being is influenced by ARC work demands. In this respect, a crucial characteristic of ARC work was its physicality. Consistent with extant research, several participants were overwhelmed by the predominance of physical tasks in their daily personal care routines (Yeung & Chan, 2012). The negative well-being effects of the physically draining personal cares were exacerbated by heavy workloads and the pressure of work due to understaffing and limited time to complete personal cares. As a result, and as captured in extant literature, the care workers complained about musculoskeletal pain and fatigue, which compromised their ability to actively participate in other facets of their non-work lives (Oakman et al., 2014). Additionally, understaffing has also been discussed as a major contributor to negative workplace well-being (Tuckett et al., 2009).

Concerns about the physically demanding aspects of care work including heavy workloads are closely linked to the other conclusion: the impact of the ability or inability to provide holistic care to residents and their impact on workplace well-being. Due to understaffing and shortage of time, the resultant care speed-ups left some participants with time enough only for the physical personal care needs of their residents negating

the relational needs (Armstrong et al., 2009; 2011; Banerjee et al., 2015; Daly & Szebehely, 2012; Hart et al., 2019; Wolkowitz, 2006). The participants' feelings of guilt for not providing holistic care show that those experiences of work also affect personal life.

Additionally, work equipment impacts well-being. In this study, the lack of adequate work equipment such as protective clothing and gloves as well as there being a limited supply of incontinence pads for residents combined to generate frustrations as participants feared passing on, or contracting infections from, the residents. This demonstrates that well-being is intertwined with care workers' health and safety concerns including perceptions of how effective they are in providing adequate care to their residents. The connection between migrant workers, precarious employment poor working environments and poor health is well documented (Benach, & Muntaner, 2007; Lewis et al., 2015; Hargreaves et al., 2019; Moyce & Schenker, 2018; Standing, 2011; Yanar et al., 2018).

As captured in the model (Figure 8.1), this study demonstrated that aged care as body work provides a particularly useful and as yet underexplored opportunity for examining the well-being and workplace experiences interface in a context of migrant care workers. The social constructions of residential aged care work as 'dirty' (Clarke & Ravenswood, 2019; Ostaszkiewicz et al., 2016), 'body work' (Isaksen, 2002b; Twigg et al., 2011) significantly impacts workplace well-being. For example, several participants were disgusted by the "intimate, messy contact with the… body, its orifices or products through touch or close proximity" (Wolkowitz, 2006, p. 8) that constitute personal care (Fisher, 2009).

At the same time, a notion of aged care as manual dirty work renders it of low social standing which ultimately impacts well-being. Consistent with previous studies, several participants associated the dirty aspects of care work with negative social standing (Campbell, 2020) and various other forms of taint such as physical, social, and emotional (Ashforth & Kreiner, 1999; Hughes, 1951, 1958; 1962; McMurray & Ward, 2014; Ostaszkiewicz et al., 2016). As a result, several participants were not comfortable with disclosing the identity of their job to family and friends in the home country. With few exceptions, dirty work is therefore considered harmful work (Bergman & Chalkley 2007; McMurray, 2012).

As argued by Goforth "everybody has a need for something bigger in life than just making money and going to work" (2001, p. k-2). In this respect, Karakas (2010) defined spirituality as "the journey to find a sustainable, authentic, meaningful, holistic,

and profound understanding of the existential self and its relationship/ interconnectedness with the sacred and the transcendent" (p. 91). These views resonate with Goodloe & Arreola's (1992) who argued that spirituality at work is linked to meaning and purpose, self-transcendence, social and spiritual actions with others, oneness with nature, and personal relationship with God.

This study proved that workplace well-being is influenced by perceptions of the nature of ARC work in terms of its meaningfulness (Yeoman, 2014). Amidst the frustration of dealing with the generally poor conditions of work, several participants derived some job satisfaction from the meaningfulness of helping dependent residents whose personal care needs have suffered partly due to local born workers refusing to take up the physically and emotionally challenging poorly paid ARC work (Anderson & Ruhs, 2008; Van Hooren, 2014).

The wide consensus is that 'work is an inescapably valuable' (Thomson, 2005, p. 84) essential human need (Yeoman, 2014). Terkel argues that "Working is about the search for daily meaning as well as daily bread, for recognition as well as cash, for astonishment rather than torpor; in short, for a sort of life rather than a Monday through Friday sort of dying" (1974, p.1). In this respect, a characteristic of ARC with significant well-being implications was that even though residential aged care work is socially constructed as a low status and highly stigmatised job (Ashforth & Kreiner, 1999; Manchha et al., 2021; Ostaszkiewicz et al., 2016), the participants that considered caring as a vocation or a calling continued to revel in providing affective care to their residents.

The poor conditions of aged care work, for example, heavy workload, confronting aspects of personal care and poor salary were a significant source of strain for several participants. However, a few of the participants countered these challenges by drawing calling as a resource that helped them to restore meaning and intrinsic reward to their work. Viewing aged care work as sense of calling or as personally fulfilling and socially significant work provided them with a strong enough motivator to persevere even in the face of significant aged care work practice challenges. It is argued that those that work with a sense of calling do not work for financial reward or advancement but for the fulfilment and intrinsic meaning that doing the work bring (Yoon et al., 2017; Dik & Duffy, 2009).

This study confirmed that the intrinsic satisfaction that arises from taking care of residents can co-exist with the dissatisfaction arising from the other poor aged care working conditions (Carr, 2014). The care workers who were able to find meaning and

dignity in ARC work slightly ameliorated the physical, social, and emotional stains associated with aged care as dirty body work (Ashforth & Kreiner, 2013; Kreiner et al., 2006). As a result, it is concluded that perceiving work as a calling buffers the well-being harmful impacts of poor ARC work conditions (King et al., 2013). The downside of this complicated relationship between poor working conditions and work as a calling is that research and policy has often abused it to keep wages low for women and more specifically migrant women in their jobs as care workers (King & Meagher, 2009a, 2009b).

At the same time, given the gendered nature of aged care work, the findings reflect some interesting well-being dynamics from the perspective of the male care workers. Whilst admitting that they considered aged care meaningful work, they could not reconcile their positions as aged care workers with the undervalued and socially stigmatised constructions of aged care work (Kreiner et al., 2006). As a result, they nursed feelings of being 'pariahs' (Hughes, 1962, p.7) or a member of the out-groups. In this respect the study concludes that masculine perceptions of aged care body work as feminine work significantly impacted workplace well-being. The male care workers that perceived loss of masculinity or felt less than 'real men' (Lupton, 2000) prove that masculinity is a precarious social construction which can easily be lost, with significant social and psychological well-being ramifications for men in female dominated work (Berdahl et al., 2018; Cohen & Wolkowitz, 2018; Vandello & Bosson, 2013). Whilst some studies have argued that men who enter female-dominated occupations take their gender privilege with them resulting in better benefits for them (Moskos & Isherwood, 2019), none of the men in this study felt that way. They were preoccupied with their damaged egos and feelings of shame associated with doing a woman's job. Notwithstanding the small study sample size, it can be argued that a gendered approach to experiences of work potentially provides opportunities to understand men's working lives, especially their vulnerabilities with respect to their wounded masculinities in doing traditionally feminine aged care roles. As it is, there is a dearth of studies not only in New Zealand but internationally as well that have taken this angle in examining the experiences of migrant men who take up jobs in female dominated professions.

The study shows that care workers are challenged by the nature of the aged care job, especially performing personal cares, including other physically and emotionally demanding aspects of the aged care job. As a result, care workers experienced these difficult work conditions. This resulted in some of them experiencing guilt from knowing that their elderly residents expected a certain standard of care which the care workers were unable to provide. The care workers did not feel confident to provide holistic care

to their residents. Therefore, experiences of work were either poor or positive depending on the adequacy of training in both soft and physical aspects of care such as emotional labour coping skills to deal with the emotionally taxing, stressful, and anxiety-provoking occurrences within aged care work settings, such as the death of residents. The concerns of the Office of the Auditor General (2012) a decade ago about aged care workers' lack of requisite skills to deliver high quality of care are still relevant today. Previous studies have also observed that care workers lack preparedness to deal with resident death for example (van Riesenbeck et al., 2015). However, care in institutional settings has for decades been critically affected by a cost control and profit-making imperative resulting in insufficient training (Glenn, 2000). Additionally, consider that migrant care workers are operating in a new multicultural service delivery environment, (Cangiano & Shutes, 2010; Walsh & Shutes, 2013a, 2013b), it can be argued that they require cross cultural training to better support them in their roles (Brooke et al., 2018).

Additionally, several aged care work conditions and relationships affect migrant care workers' personal life. Performing the confronting dirty aspects of the job worsened several participants' perception of their life conditions than would have been the case with other jobs. The poor aged care working conditions significantly impacted quality of life, in the sense that participants associated them with lower quality of life or lower life satisfaction. Research has established that poor quality jobs with a high preponderance of several psychosocial stressors are as bad for health as being unemployed (Broom et al., 2006).

One of the aspects of the quality of the work environment that impacted well-being was the concept of job control. Generally, lack of job control is associated with poor workplace well-being. In a context of migrant participation in ARC, lack of job control raised concerns about the migrants' sense of dignity and personhood in the workplace. For example, the participants that had previous nurse training were concerned about the lack of job control because not only did it deny them the opportunity to use their skills, but it also communicated the message that the managers did not value their previous educational and training accomplishments. As a result, they felt devalued which impacted on their self-perception and dignity within and outside the work environment. A lack of job control is disorienting for many workers as it makes them lose sense of the meaningfulness of what they do as well as their role and value in the desired patient health outcomes (Portoghese et al., 2014). At the same time, whilst it is understandable that non-application of one's skills is demoralising, it is important to note that they are employed to be care workers and therefore wrong to expect them to

bring all their other skills to this new role, when most of the previous skills and educational qualifications are not being paid for

In the same vein, the level of remuneration impact personal life. Consistent with extant literature, this study recorded strong links between workplace well-being and remuneration (Osterman, 2017). Empirical evidence confirms that income is an important factor that positively contributes to immigrants' psychological well-being (Jibeen & Khalid, 2010). As a result of poor pay, some of this this thesis' participants had multiple jobs. Effectively this compromised their ability to meet their out of work life commitments. The poor remuneration was associated with low social standing of the job causing them significant job stigmatisation stress. The relatively poor pay of aged care workers is commonly conceptualised as 'care penalty' (England et al., 2002; Palmer and Eveline 2012) which generates experiences of devaluation and non-recognition (Huang, 2016; Krawietz & Visel, 2015; Ochsenfeld, 2014). Care work is undervalued largely because "care enters the market as historically gendered and domesticated practices" (Green & Lawson, 2011, p.650).

Irregular hours and shifts impact personal life and well-being. The aged care work conditions impacted significantly on work life balance for example. There is strong evidence that show that work-life balance is key to workplace well-being (Baptiste, 2005; 2008; Danna & Griffin, 1999). From the findings, it can be concluded that several shift work characteristics (e.g., shift length, working weekends) impact well-being in terms of work-to-family conflict (Barnes-Farrell et al., 2008). Findings show that shift and on call schedules contribute positively to the well-being of parents, especially, women struggling to reconcile the competing demands of work and motherhood. Shifts ensured that at least one parent was available at home to take care of the children and address various family religious and social commitments. Well-managed shift work has been shown to improve employees' sense of work-life balance and their well-being (Agosti et al., 2015; Campbell, 2018; Clarke, 2015; Spasova et al., 2018).

At the same time, it can be concluded that for migrants who have limited social support to balance their work and life commitments, working shifts implies high levels of physical, social and emotional involvement. Migrants cannot afford not to work especially because being employed is often their license to stay in the host country (Dyer et al., 2011). In the same vein, care work combined with the competing time demands for the multiple jobs the participants held, consumed large amounts of their working days and nights often encroaching on evenings and weekends. Traditionally these times are associated with family activities and commitments (Ungerson, & Yeandle, 2005). In this respect, several participants complained that shift work

compromised their ability to plan in relation to their personal life outside work commitments. This shows that time at work structures all other aspects of daily life, impacting profoundly on the life of the employees both on and off the job. Shifts are therefore both a problem and a solution to the work–family and life balance tensions experienced by employed migrant parents.

One of the over-arching themes of this thesis is the way migrants struggle with marginal living. Several participants considered themselves as outsiders, for example regarding labour market opportunities and workplace relationships. They therefore were worried as much about isolation and exclusion as they were about providing for their livelihood on poor pay. They struggled with the perception of being treated as workers who were mostly interested in the economic benefits of migration. These experiences or perceptions negatively impacted several workers' social and psychological well-being by limiting their ability to feel a sense of belonging (Caxaj & Diaz, 2018). As indicated in the literature, experiences of belonging are contingent on several dimensions, including time, space, affective, and relational elements (Gustafson, 2009). Experiences of belonging are also a result of social bonds. For several migrant care workers in this thesis, these social bonds were largely constrained and shaped by poor pay that forced most of them to take more than one job. Additionally, their sense of belonging was impacted negatively by perceptions of discrimination and unfair workload allocation (Boese & Phillips, 2017). As migrants and new to the country, having time to connect and integrate into the community is vitally important. However, difficult working times hindered the possibility of them feeling settled and developing a sense of place or belonging. The third and final research question examined the impact of workplace relationships on the migrant care workers' well-being. As captured in the model (Figure 8.1), work relationships are a component of the 'quality of the work environment'. Past studies have noted that workplace relationships between the participants and their managers, residents, co-workers, and relatives of their residents' influence well-being (Ball et al., 2009; Hoff, et al., 2010; Moss et al., 2002; Timonen & Doyle, 2010a; 2010b). The study found that well-being suffers when there are poor relationships between employees and managers. Perception of discrimination, and unfairness on the part of managers regarding allocation of shifts, residents, and a perceived lack of managers' interest in attending to migrants' workplace challenges had significant negative well-being impacts. At the same time, the managers that helped the participants to manage work and life or allocated them family friendly shifts enhanced the participants' well-being. Past studies have noted that a lack of social support at work is a predictor of well-being impairment (Stansfeld & Candy, 2006; Stansfeld et al., 2008; 2013) whilst well-managed shift work

improves employees' sense of work-life balance and their well-being (Agosti et al., 2015).

Co-worker relationships impact workplace well-being. The relationships with co-workers impacted positively on both their work and personal lives as they felt accepted by the host country community. This is consistent with studies elsewhere that noted that co-worker relationships act as the basis for cooperation and therefore are an important resource for accomplishing work tasks (Mikkola & Nykänen, 2020).

Linked closely to the above conclusion is that relationships with residents also impact workplace well-being. Residents were a significant source of human connection for migrants who lacked social and family support in the country of relocation. Past research has noted that migrant care workers' ethnic/racial background, language barriers, among other factors compromise the ability of care workers to create fulfilling relationships with their residents (Bourgeault et al., 2010). This study did not record any concerns with language barriers, but there were instances of negative experiences with some residents who were abusive and racist. Although discrimination can be experienced by both the immigrant and local population of the host country, immigrants who emigrated under more precarious circumstances and secure less socially respected jobs can be particularly vulnerable to it (MacKay et al., 2006).

However, over time, except for instances of racism and verbal abuse, interactions became more family like (Baldassar et al., 2017; Moss et al., 2003; Piercy, 2000). Social bonds with residents are therefore valuable for the well-being of migrants dealing with various stresses caused by an unfamiliar environment and physical separation from their family (Adhikary et al., 2018; Bourgeault et al., 2010; Chib et al., 2013).The residents enable them to satisfy the needs for belonging thereby enhancing their social well-being.

Although everyday interactions with residents enhance workplace well-being, they can also diminish it. In this respect, the social bonds created between participants and the residents were ironically a source of psychological and emotional strain. Consistent with past research, several participants became too attached to their residents' lives, which, in the absence of emotional labour coping skills, left them exposed to severe stress when any of the residents they cared for died (Boerner et al., 2015; Kinman & Leggetter, 2016; Moss et al., 2003; Vegchel et al., 2004). Despite the documented therapeutic value of relationships between residents and care providers (Andrews, 2004; McGilton & Boscart, 2007; Morse et al., 1992, Li, 2004), no empirical studies were found that examined the migrant care worker–resident relationship within the

context of the New Zealand ARC sector. Despite the increased participation of migrants in aged care service provision as well as the established evidence of "emotional toxin'' (Obholzer, 2005) such as anxiety and stress associated with loss and bereavement, there is a dearth of New Zealand based literature on this theme.

Research limitations

It is pertinent to note that there are some limitations to this study. The small sample size used (n=23), points to the importance of small, purposively selected samples to allow for a richer, in-depth analysis of the phenomenon under investigation in qualitative research (Charlick et al., 2016). One of the objectives of this study was to give voice to a group of migrant care workers who have received limited attention in extant studies in New Zealand ARC. Nonetheless, it could be argued that the sample of 23 participants is relatively small. Some readers of this thesis might therefore share Morse's (1995, p.147) argument that although "data saturation is the key to excellent qualitative work …" the concept remains elusive concept since few concrete guidelines exist. As indicated in Chapter Five (Methodology) the application of theoretical data saturation was not based on the quantity of data but richness of data (Morse 1995; 2015). As the interviewing process reached participant 23, there was evidence of rich data derived from detailed descriptions and not the number of times a point was mentioned (Morse, 2015). This was therefore key in determining when to stop the interviewing process.

Another potential limitation is that the 23 participants could have been more homogenous in terms of nationality and gender to enable unearthing richer insights into the nexus between well-being and work experiences. Some researchers might also argue that a lack of homogeneity in participants inhibits generalisability of the findings (Bambra, 2011). At the same time, the interpretivist ontological and epistemological premises of this study counter this argument. Ontologically, this study shared a view of the existence of multiple realities that are individually constructed (Guba, 1981; Iosifides, 2018). In this context, although care workers from the same country might share some common interpretations of the quality of the work environment and its impacts on workplace well-being, of much concern to this thesis was how well-being interfaced with individual workplace experiences. This goal was achieved regardless of the 'diversity of the participants' backgrounds. However, future studies could investigate workplace well-being from the perspective of migrant care workers from Western high-income countries. This would enable a better understanding of

differences and similarities with the findings of this thesis that examined perspectives of care workers from a perspective of employees who are predominantly from developing or low-income countries.

The role of pay in well-being remains a critical issue of concern. Although some of the participants downplayed its well-being significance, they were forced to have multiple jobs to generate more income which in turn impacted their work life balance. This thesis commenced before the April 2017 New Zealand Government $2 billion Pay Equity Settlement for 55,000 low-paid aged care, disability and community support services workers which became effective from July 1, 2017. This is a potential limitation of this thesis given the significance of pay to workplace well-being (Burd, 2012; Mucci et al., 2020). Future research could look at the well-being of migrant care workers considering the changes in pay structure.

Contribution to well-being literature

The thesis contributes to well-being literature by noting that employees' experience is constituted in the everyday interactions that occur on the job. This thesis argued that for all their advantages, strengths, and insights into how well-being interlocks with workplace settings, extant theoretical models that were extensively reviewed in Chapter Two, do not adequately capture the deeper embedded macro-organisational factors surrounding the organisation of work and their implications for workplace well-being in a migrant care worker context. Most of the extant models explain well-being by focusing on the role of organisation specific factors such as job demands and other organisation specific factors (Danna & Griffin, 1999; Kubicek et al., 2015; Ravenswood et al., 2017). However, the larger societal structures and conditions that create the framework in which these issues arise are frequently overlooked.

Migrant workers endure stress emanating from, for example, socio-environmental variables, such as loss of social status, discrimination, and separations from the family (Mucci et al., 2020). As argued by King-Dejardin (2019), migrant care workers embody a range of social identities that put them at a greater disadvantage in host countries than non-migrant care workers and other nationals. Their migrant identity suggests that they are ‘outsiders’ in the host country which partly explains why they generally end up in “3D”: dirty, difficult, and dangerous (Michel, 2010) or ‘dirty, dangerous and dull’ (Favell, 2008) jobs in host countries. Compared to non-migrants, they tend to experience several unfair employment practices such as lack of recognition of their

foreign credentials and qualifications (Walton-Roberts, 2020a; 2020b). As outsiders, they are 'matter out of place' which ironically is reminiscent of constructions of body work as 'matter out of place' rendering it "low in socio-symbolic status and value and thus the province of migrant workers as 'people out of place' (Dyer et al., 2008, p.2032; see also Huang et al., 2012).

This thesis suggests that fostering positive well-being outcomes for migrant care workers, requires understanding that migrant agency is largely mediated by a plethora of factors including pre-migration individual circumstances, migrant identities or race, gender, and temporary visa or immigration status (Hamilton et al., 2019; Turnpenny & Hussein, 2021). As this thesis' proved, an examination of well-being in a context of migrant care workers benefits substantially from an examination of the context of migration, migrant status in terms of their influence on the ways migrant care workers interact with aspects of the work environment that are known to impact well-being such as poor working conditions and workplace relationships (Hussein & Manthorpe, 2014). The employment of migrants in aged care jobs that are characterised by non-standard work patterns make it difficult for them to find opportunities to develop social ties and support.

Therefore, this thesis' incorporation of migrants' identities and dirty work theory into an examination of workplace well-being of migrant care workers is a significant addition to the well-being literature as captured in Figure 8.1: *Framework of Factors Affecting the Well-Being of Migrant Care Workers.*

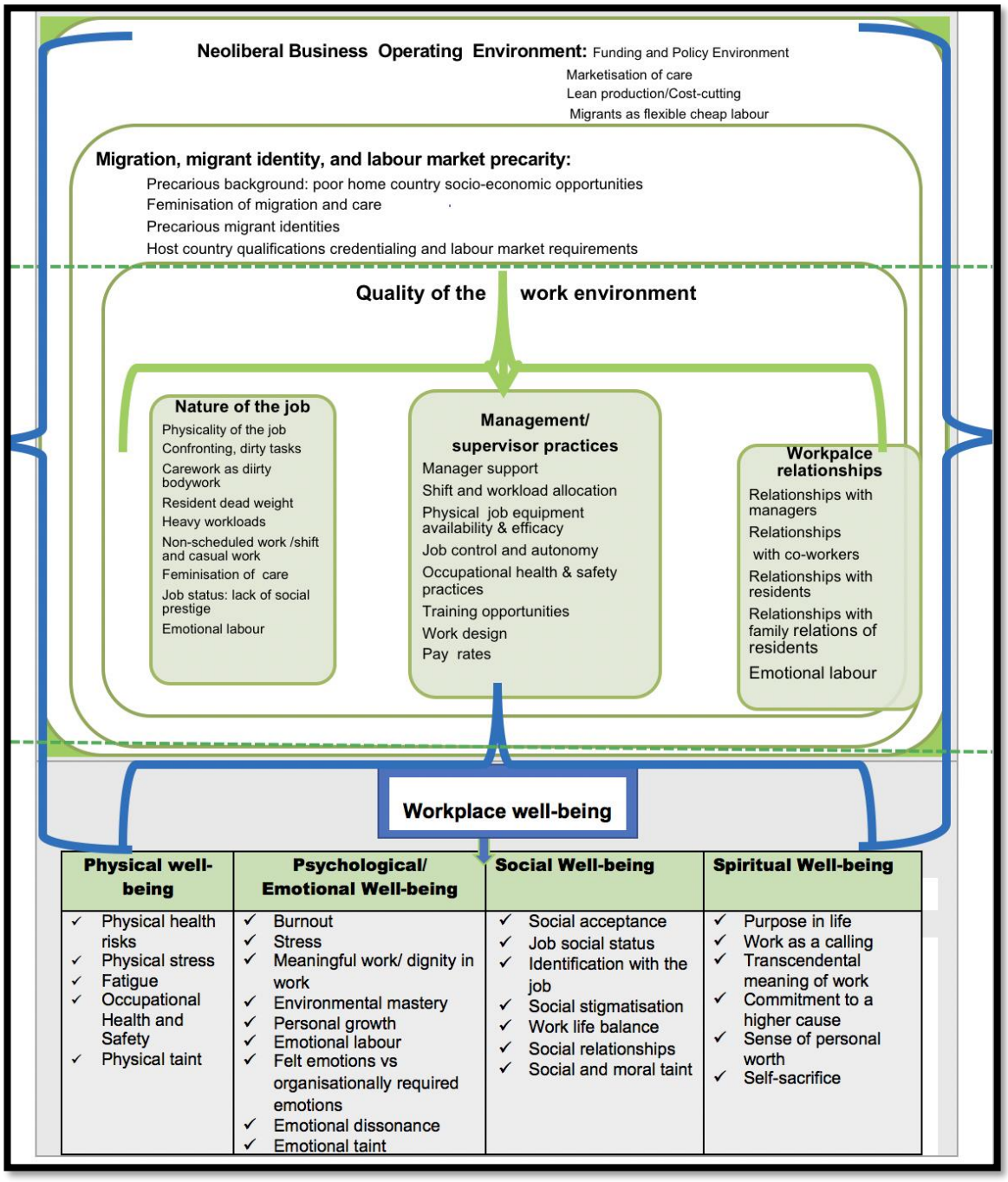


Figure 8.7 Framework of Factors Affecting the Well-Being of Migrant Care Workers

Figure 8.1 demonstrates that well-being in a context of migrant care workers' work experiences, is influenced by interactions among four major factors. Care work is shaped by micro, meso, and macro levels of any political economy (Williams,2012). The working conditions in Aged residential care in New Zealand or other Western countries, are shaped by micro-level interactions of social actors within the context of the market-model, and also by the broad neoliberal ideologies and interests that subject care to the demands of individualization, profit-maximization, privatization, and

cut-backs (Day, 2014). In the model, two broad factors of migrant identity and quality of the work environment are nested within a larger neoliberal business policy environment. As argued by Mills (1959), there is a connection between historical times and individual lives. In this respect, the vulnerable and precarious identities of migrants that deterred the participants from asserting their work rights cannot be divorced from the personal circumstances accounting for their immigration.

Figure 8.1 demonstrates therefore that the participation of migrants in aged care in the Western countries and the working conditions the migrants encounter thereof, are happening within a global policy environment of neoliberal austerity (Parren˜as, 2001; Schwiter et al., 2018). Indeed, it can be argued that the generally poor aged care sector working conditions identified in this thesis which are also reflected in extant literature (Burrow et al., 2017; Charlesworth & Isherwood, 2020; Hodgkin et al, 2017; Kaine & Ravenswood, 2014; King et al., 2013; Lazonby, 2007; Ravenswood & Douglas, 2017; Ravenswood, et al., 2017; Shannon & McKenzie-Green, 2016) reflect specific organisation dynamics, such as poor management styles or poor attitudes of owners of aged care facilities towards the quality of aged care and employee well-being. At the same time, it could also be argued that organisation-specific work environment factors that are critical to workplace well-being do not exist in a vacuum. For example, Rana et al. (2014) argued that workplace practices related to employee engagement take place within a broad policy environment of legal, political, socio-cultural, technological and economic forces that are largely beyond the influence of individual organisations. This resonates with Hussen & Manthorpe's (2014) study which found that although ARC is provided by the private sector in the UK, their employees' pay levels are largely determined by, among other factors, extra organisational factors such as constraints in state funding for those eligible for publicly funded care.

Although primary data for this study were drawn only from individual employees at the different aged care organisations, this critical theoretical broad contextual analysis was included in this study to enable a more critical interpretation of the responses of the interviewed participants about the nature of the interaction between well-being and work experiences. A neoliberal austerity rationality in public spending and the neoliberal restructuring of public health services reflected in the prevalence of private providers in the aged care sector is also in part responsible for the hiring of a flexible, inexpensive migrant work force (Parren˜as, 2001; Pratt, 2004, 2005; Shamir, 2013) to address the care deficit. Neoliberal rationality can therefore not be separated from the type of working conditions experienced by migrant care workers in individual aged care facilities (Schwiter, et al.,2018a,2018b). This study's review of neoliberalism and how it

is implicated in migration, and migrant identities that are defined largely by precariousness and vulnerability encourage the reader of this thesis to adopt a critical interpretivist perspective in analysing the interface between well-being and work experiences in a context of migrant care workers by placing this interface in a larger policy context. Figure 8.1 shows the interaction among micro and macro levels of the work environment that impacts migrant care workers' well-being. The micro level refers to the day-to-day care relationships between workers, aged residential patients, employers and associated work conditions. The macro scale refers to the neoliberal context in which aged care is often supplied by migrant workers. As already discussed, migrant identity is a product of several aspects, for example, constrained pre-migration socio-economic personal circumstances, lack of acceptable labour market requirements in the host country, race, and temporariness or lack of belonging that is reflected in the holding of a temporary visa, that add up to generate precarities and vulnerabilities in the migrant identities and lives. The migrant identity as a label is encapsulated in the states of 'temporariness' and lack of social support and traditional networks, as well as lack of what is required by the host country's labour market. Migrants don't belong where they are and therefore their identity can be described as an 'outsider' which ultimately underlines the precariousness of their lives in the host country.

The vulnerable identities of migrants cannot therefore be divorced from the reality that, essentially, migrants are a neoliberal object designed to help Western governments deliver quality care at minimal costs in line with neoliberal fundamentals. "Migrants represent cheaper options to deal with labour shortages in many economic sectors, especially of industrialised Western countries (Joppe, 2012). The conditions of work that migrants encounter in the host country are designed to achieve that goal. It could also be argued that this is part of the structural marginalisation of migrants because the migrants are brought into an environment in which their usefulness is determined by their role in helping the Western nations to provide health care to their citizens at minimal costs. Migrants are brought into a business policy environment designed to get as much as it can from them with as little investment into them as is possible. As argued elsewhere, the employment of migrant workers in low waged care work is shapped both by the neoliberal fundamental of marketisation of care as well as immigration controls (Shutes & Chiatti, 2012; (Liu, 2015).

The thesis therefore provided a strong case for considering the role of macro scale issues of care regimes or the larger policy and funding environment which reflects how countries care for their elderly (Estes, 2014; Mercille, 2018). Globally, care regimes

including New Zealand's, are increasingly being shaped by neoliberalism as reflected by, among other factors, the increased participation of for-profit organisations in aged residential care whose production methods are not always consistent with conditions that support well-being (Boyd et al., 2009; Kilian, 2018; Lazonby, 2007). The most significant conclusion in this respect is that the tenets of neoliberalism such as lean production, cost-cutting, market-based employment practices, and profit making (Cooper & Ellem 2008) are not aligned with work settings that promote employment conditions and work design methods that can promote workplace well-being (Crowley & Hodson, 2014; Kalleberg, 2009; Shutes & Chiatti, 2012; Smith 2010). Heavy workloads, shortages of incontinence pads for residents, and inadequate protective clothing for the staff that impacted significantly on the physical well-being of the participants are an indication of prevalence of lean production techniques and cost cutting measures that are characteristic of aged care work settings that are influenced by a neoliberalism profit imperative (Henderson & Willis, 2020; Mercille, 2018; Shamir, 2013; Misra et al., 2006; Parren˜as, 2001; Pratt, 2004, 2005;).

Recommendations for future research

The study sample includes employees from developing countries, all 'people of colour'. Further studies could include white migrants from developed countries as well to gauge if their experiences of care work differ from the experiences of migrants from generally poor developing nations. Additionally, a comparative study of immigrants and non-migrant care workers could deepen understanding of how the experiences of work impact on workplace well-being. This is likely to enhance understanding of the role of migrant status and racism in well-being. International studies have documented that migrant care workers experience discrimination and racism in the workplace, for example (see Behtoui et al., 2020; Sahraoui, 2020; Stevens et al., 2012). This thesis suggests that racism contributes to negative well-being. There is need for empirical analysis of this issue within the New Zealand aged residential care sector.

As indicated in the section about limitations of this thesis, the interviewing process started before the 2017 Pay Equity. As indicated in the literature review, levels of pay play a crucial role in shaping workplace well-being. This is a potential limitation of this thesis given the significance of pay to workplace well-being. Future research could look at the well-being of migrants care workers considering the changes in pay structure Additionally, considering the intersections between migration, migrant status, gender, and race in shaping the workplace well-being of the migrant care workers, future research can apply intersectionality theory (Yuval-Davis, 2006) as analytical lens to examine how these factors including ethnicity and class intersect and operate in the

workplace and their implications for the multiple forms of marginalisation relevant to migrant care workers' workplace well-being.

Workplace practice implications and recommendations

In seeking to gain to gain an understanding of well-being in relation to migrant care workers' work experiences, this thesis illuminated several areas that may be relevant to policy and practice in the New Zealand residential aged care sector. One of the aims of this thesis was to contribute to practice by suggesting ways to improve migrant care workers' working conditions. This thesis unearthed some new understandings about how workplace-well-being interfaces with workplace experiences in a migrant worker context. This thesis encourages more reflection on the part of all key ARC stakeholders about various issues associated with the participation of migrants and what can be done to improve their workplace well-being. Current studies have noted that workers that experience poor workplace well-being are more likely to be less productive and to make poor quality decisions (Haddon, 2018; Kowalski & Loretto, 2017; Kun et al., 2017; Danna & Griffin, 1999, Sears et al., 2013). From a quality-of-care perspective, this raises significant questions about the role of the migrants that are increasingly participating in care delivery, yet they suffer from some challenges associated with their migration, migrant status and generic poor aged care working conditions. These findings provide a point of reflection for aged care facility owners and managers to think about how the immediate aged care environment combined with macro scale issues of care regimes, policy and funding affect workplace well-being as well as reflecting on strategies that can be implemented to create environments that support improved well-being. This is critical because the well-being of the workers is intricately intertwined with the quality of care they can deliver and the well-being of the residents (Clarke & Hill, 2012).

This thesis speaks to the important role of training. Most of the challenges experienced by the migrants revolve around inability to adjust to the nature of personal cares and operating in a new work environment. Migrant care workers are more vulnerable to risks created by the intimate nature of care work (Christensen & Manthorpe, 2016). The thesis found that some of the migrant care workers were overwhelmed with the emotionality of aged care work including the high levels of responsibility for the welfare of their residents. Although emotional labour did not result in dissonance for a few participants, this thesis found that most participants experienced a conflict between their emotions and the requirements of their roles (Abraham, 1999; Hochschild (2012). This accentuates the importance of putting in place support structures for migrant care workers to minimize adverse emotional age care role experiences. Due to the

emotionally demanding nature of caring work and its impact on well-being, migrants require training in emotional aspects of care work. Kinman & Leggetter (2016) emphasise the importance of interventions that equip health care staff to better cope with the emotional demands of their work. In the same vein, Eyers (2000) emphasised the need to implement training that improves the emotional labour skills of care workers as a strategy to improve the experience of all participants in the care environment.

Furthermore, this thesis provides a strong case for key policy makers, and managers of aged care facilities to clarify their understanding of what constitutes quality of care for residents. As it is, against the background of the resident-centred-care rhetoric, the practice shows that caring for residents is mostly about attending to their physical personal care which was also not adequately attended to due to shortage of time, understaffing, and heavy workloads. The care workers observed that their residents valued holistic care that catered to all their physical and relational needs, yet there was no time for interpersonal relationships with residents. This thesis has shown that relationships between residents and care workers are vital to migrants who have limited social networking in a new country (Caxaj & Diaz, 2018). It was noted in this thesis that migrants develop familial ties with the residents who remind them of their families in the home country (Berdes et al., 2007; Mazus, 2013). Due to shortage of time coupled with heavy workloads, the resultant care speed-ups meant that the migrant care workers struggled to provide holistic care and had to live with the guilt of knowing that they could do better if these organisational constraints were removed (Armstrong et al. 2009).This to the importance of designing care systems that are built around the concept of holistic care, recognising the central role of the care worker in the health of the residents. The current rhetoric of person-centred care must match the practice.

Extant literature has documented the threat of poor conditions of work such as poor pay, physically and emotionally demanding job attributes, lack of job control, workplace relationships, and exposure to hazardous working conditions (Charlesworth & Isherwood, 2020; Fine & Mitchell, 2007; Goel and Penman, 2015; van Hooren, 2012). This thesis has built a strong case for the consideration of macro-level neoliberalism related factors within which individual migrant employee and, aged care facilities are embedded. The shortage of resources, understaffing and heavy workloads indicate a far bigger problem within the New Zealand ARC sector beyond the confines of individual aged care organisations. Systemic issues of heavy workloads, understaffing and under-resourcing speak to the need to forge more constructive strategic partnerships between critical stakeholders in the New Zealand Aged care sector

including government, for-profit and not for profit aged care facility owners, employees, and their representatives in implementing sustainable employment and resourcing changes that can impact on the well-being of the people who take care of the most vulnerable members of our society.

Conclusion

In conclusion this thesis has examined well-being in a context of migrant care workers' workplace experiences. These contexts complemented each other in interesting ways. On the one hand, the aged care sector is dominated by poor working conditions that have pushed away many local born employees to take up roles in the sector. The result is an operational tension affecting the quality of care to ADL (activities of daily life) dependent residents. On the other hand, the migrants who are being relied on to close the resulting care gap experience challenges within and outside the workplace. Previous studies have proved that any worker that experiences poor conditions of work will suffer psychosocial, physiological challenges as well as health inequities (Lewchuk et al., 2011). Regarding migrants, systemic and structural racism exacerbates their vulnerability to precarious work, underemployment, poor pay and living in persistent fear of job loss (Li, 2019; Wilson, 2019). The collective impact of all these factors on the workplace well-being of migrant care workers in ARC is however not straight forward. Some find dignity and meaningfulness in the aged care job whilst others' well-being is severely diminished. Several factors therefore impact the workplace well-being of migrant care workers in residential care. First, the work environment is a key factor, specifically, heavy workload, poor pay, and the nature of relationships between migrants and their managers, supervisors/managers, co-workers, residents, and relatives of the residents. One of the key findings of this thesis regarding the work environment is the role of the attributes of the care job and its characterisation as 'dirty body work' (Clarke & Ravenswood, 2019; Ostaszkiewicz et al., 2016) to workplace well-being. As dirty body work, aged care is associated with physical, moral, social and emotional taint or stigma. Although extant studies have examined the taint associated with aged care work, a yet underexplored issue is the analogous connection between aged care as dirt or 'matter out of place' and migrants as people 'out of place' and its implications for workplace well-being. Dirt is 'matter out of place' and migrants are effectively people who are 'out of place'. This characteristic of care work leads to its relative invisibility and a 'chronic deficit of recognition' (Macdonald & Merrill, 2002, p. 67) of care workers. Experiences of discrimination against migrants reflect that they don't belong where they are. Their legal temporary visa conditions which emphasise temporariness underscore their precarious transient existence in the host country (Reid et al., 2021; Strauss & McGrath, 2017). As argued

by La Barbera (2015) “in transit” locationality implies the deprivation of one’s family, and social networks, or the protection of one’s nation-state and the search for new symbolic and material spaces in which to stay” (p.11). They do not belong where they are and therefore struggle to meet their need for belongingness. This speaks to the important role of social networks and social support in enhancing workplace well-being of workers who operate in new multicultural service delivery environments. The third and final key finding relates to the role of the neoliberal business policy environment within which migrants and several aspects of the work environment interact. The thesis argued that the quality of the environment that impacts workplace well-being must be considered not only in conjunction with the pre- and post- migration experiences of the individual migrant care workers, but also consider the role of the larger funding and neoliberal policy environment of ARC.

Even though there is burgeoning research on workplace well-being in the New Zealand ARC sector context (for example, Ravenswood, 2011; Ravenswood & Harris, 2016; Ravenswood et al., 2017a; 2017b), very little has been written about how their well-being interlocks with workplace experiences. As is the case globally, the New Zealand aged residential care job market is generally unattractive and local workers tend to exit it as their employment opportunities improve (Callister et al., 2014; Chanamuto, 2016; Meagher, 2016; Torres, 2017). Migrants therefore continue to play a critical role in addressing the rising need for aged residential care. Notwithstanding the significant challenges that they experience in the workplace, migrants also derive substantial social, physical and social benefits from their participation in residential aged care. There are therefore significant opportunities to improve the migrants’ conditions of entry and participation in residential aged care for the mutual benefit of the migrant care workers’ well-being and the health of the residential aged care sector.

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Appendix A: Ethics Approval letters

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

14 December 2018

Katherine Ravenswood
Faculty of Business Economics and Law

Dear Katherine

Re Ethics Application: **18/423 A critical examination of employment experiences and well-being: the aged care sector**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 14 December 2021.

Standard Conditions of Approval

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/research/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/research/researchethics.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/research/researchethics.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it.. You are reminded that it is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

For any enquiries, please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: nchaderopa@hotmail.com

16/059

Academic Services

Manager, Academic Committees, Mr Gary Witte

3 November 2016

Dr F Edgar
Department of Management
Division of Commerce
School of Business

Dear Dr Edgar,

I am again writing to you concerning your proposal entitled "**How do migrant care workers in New Zealand Aged Residential Care narrate their work-life experiences?**", Ethics Committee reference number **16/059**.

Thank you to Esther Chaderopa, PhD student investigator on the above project, for her email of 2nd November 2016, with response and revised documentation attached addressing the issues raised by the Committee.

On the basis of this response, I am pleased to confirm that the proposal now has full ethical approval to proceed.

Approval is for up to three years from the date of this letter. If this project has not been completed within three years from the date of this letter, re-approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

The Human Ethics Committee asks for a Final Report to be provided upon completion of the study. The Final Report template can be found on the Human Ethics Web Page

http://www.otago.ac.nz/council/committees/committees/HumanEthicsCommittees.html

Yours sincerely,

Mr Gary Witte
Manager, Academic Committees
Tel: 479 8256
Email: gary.witte@otago.ac.nz

c.c. Professor S Grover Department of Management

Appendix B: Participant Information Sheet

Date Information Sheet Produced:

14 November 2018

Project Title

A critical examination of workplace well-being and employment experiences.

Dear Potential Participant,

My name is Nyemudzai Esther Ngocha-Chaderopa and I am currently undertaking research for my PhD qualification at Auckland University of Technology. The aim of this study is to develop a better understanding the intersections between well-being and employment experiences of migrants in the aged residential care (ARC) sector in New Zealand. It is anticipated this research will contribute to the important discussion around employee well-being. I would like to encourage you to be part of my study. Please feel free to participate and if you have any questions about my project, either now or in the future, please feel free to contact me on (nchaderopa@hotmail.com)

Regards,

Esther

What is the purpose of this research?

The purpose is to address important gaps in our understanding of employment experiences of migrant care workers, and also their well-being. Despite the growing importance of the role of migrants working in the New Zealand Aged Residential Care (ARC) sector, little is known about their employment experiences and the possible implications of these on their well-being as well on the diverse performance goals of ARC facilities.

In addition, this study will allow the researcher to complete their PhD qualification at the Auckland University of Technology (AUT).

How was I identified and why am I being invited to participate in this research?

You are being invited to participate in this study because you are a paid migrant worker in the ARC, and you do not hold New Zealand permanent residency or citizenship. You have been identified as a potential participant through a network of migrant care workers. As a potential participant, you have received an invite with this Participant Information Sheet and the contact details to ask any further questions if needed.

How do I agree to participate in this research?

Once you have reviewed and understood the information in this document, if you agree to participate in this research, you can express your interest via my email

nchaderopa@hotmail.com . I will send you a soft copy of the Consent Form for you to read and sign before the interviews take place. You have one week to go through this information and request any further clarification.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

As a participant, you will be asked questions related to your work and well-being. This will require approximately one hour of your time. Please note that I will be recording the interview and taking field notes. All the information that you share will be strictly for use in this study only. After the interview, you will be given the opportunity to review and comment on the transcript of the interview before it is used in this study. You will be given one week to review the interview transcript.

What are the discomforts and risks?

There are no anticipated discomforts and risks associated with this study. We will agree to a time and venue you are comfortable with. If at any time during the interview you feel any discomfort (emotional, questions or the environment) you can choose to stop the interview or take a break. If after reviewing your transcript you choose to change your answers, you will be welcome to do so.

Once the transcript of the interview is ready, it will be shared with you so you will have the opportunity to review and comment on it before it is used for this research.

What are the benefits?

From a research perspective, despite the increased role of migrants in looking after the elderly, there is little established or accumulated body of knowledge or studies of migrant care workers in New Zealand. This means therefore that there are many aspects of this group of carers that are not known. With this in consideration, the purpose of this study is to address important gaps in the understanding of the impact of employment experiences on the well-being of migrant care workers. It is noted that there is increasing research into the work experiences of employees in residential aged care in New Zealand, but none of the current research has addressed the intersections between the well-being of these workers and their workplace experiences.

While you personally may not benefit from the study, by increasing the understanding of the sector and the experiences of migrant care workers the sector may in the future

be able to meet the needs of migrant care workers. It is hoped that the findings of this study may influence better management and practices in the workplace.

As the researcher, I will benefit from this research as well. I will gain a deeper understanding of the employment experiences of migrant care workers in New Zealand, especially the impacts of these experiences on their well-being, and this will enable me to complete my research degree.

How will my privacy be protected?

Your views will be treated confidentially, and your identity will not be disclosed. Interviews shall be carried out individually and, in a place, you feel will provide you with maximum confidentiality. If you choose to withdraw from the study during or after the interviews, your transcripts will be discarded. The transcription of the interview will be shared with you for your review and comment.

What are the costs of participating in this research?

It will require approximately 60 minutes of your time. There will not be any additional cost.

What opportunity do I have to consider this invitation?

Once you have expressed an interest to be part of this study, you will be sent a Consent Form. You will have one week after you receive the Consent Form to consider the invitation to participate in this study. During that week, you will also be given the opportunity to ask any questions regarding your participation in the research project.

Will I receive feedback on the results of this research?

Yes, you will have one week to review and comment on the interview transcript. Also, you can receive a summary of the findings of this study if you wish.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, *Associate Professor Katherine Ravenswood* (katherine.ravenswood@aut.ac.nz)

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Nyemudzai Esther Ngocha-Chaderopa nchaderopa@hotmail.com

Project Supervisor Contact Details:

Associate Professor Katherine Ravenswood (katherine.ravenswood@aut.ac.nz)

Dr. Julie Douglas (julie.douglas@aut.ac.nz)

Approved by the Auckland University of Technology Ethics Committee on *14 December 2018*, AUTEC Reference number *18/423*

Appendix C: Consent Form

Project title: A critical examination of workplace well-being and employment experiences

Project Supervisor: Associate Professor Katherine Ravenswood and Dr Julie Douglas

Researcher: **Nyemudzai Esther Ngocha-Chaderopa**

- ○ I have read and understood the information provided about this research project in the Information Sheet dated dd mm yyyy.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No

Participant's signature:……

Participant's name: .....……

Participant's Contact Details (if appropriate):

……..

……..

……..

Date:

Approved by the Auckland University of Technology Ethics Committee on 14 December 2018, AUTEC Reference number 18/423

Note: The Participant should retain a copy of this form.