PATHWAYS TO METROPOLIS IN THE 21ST CENTURY:
IMMIGRATION ISSUES AND FUTURES
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PATHWAYS TO THE COSMOPOLIS?
TRANSNATIONAL HEALTHCARE WORKERS
AND THE POLITICS OF CAREWORK IN
SINGAPORE

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Increasing vein of literature on the contested place of the migrant in the cities of the North and South, most often drawing on frameworks of integration, multiculturalism and cosmopolitanism.

Based on cities such as New York, a ‘global city’ culture founded upon a particular standard of diversity and conviviality has become the normative version of the ‘global (multi)cultural city’.
Introduction

- Much of the literature pays little heed to gender dynamics and accords little value in particular to the **social reproductive work that female migrants perform** in actively shaping the urban contexts in which they live.

- In spite of arguments developed within **feminist scholarship**
  - inextricable links between the simultaneous globalization of productive and reproductive labour (Truong)
  - construction of a ‘female privatized global space’ in the metropoles crucial to securing all aspects of the reproduction of the global managerial labour force (Weyland)
  - the place of low paid immigrant workers (largely female) in formulating her global city hypothesis (Sassen)
Blindspot stems from the tendency to focus on masculinised versions of the globopolis, usually equated with creativity and public civility, as an accompanying if not necessary condition for developing productive relations in the field of business and enterprise.

As seen in Florida’s work that uses the city’s ability to attract the creative class as the barometer of the city’s appeal for talented people and hi-tech industries, which in turn confers the city its place in the global hierarchy of cities.
Argument: towards a shift of perspective

- Shift attention to the more *feminized spheres* oriented towards the private arena away from public display to be able to better glimpse *‘actually existing’ cosmopolitanism* at work and the conditions under which these sensibilities develop.

- Move ‘beyond the public sphere into *more private and affective spaces* of the city’ in our search for ‘cosmopolitan neighbourliness’ (Datta).

- This is not to negate the findings of feminist analyses that suggest that carework, particularly in globalizing cities restructured by neoliberal agendas, reproduces and extends *forms of social inequalities* (Tronto).
Argument: focusing on carework?

- As the locus of carework shifts from local to foreign women from less developed countries, patriarchal norms and unequal gender relations are reinforced, and in fact intersect with other power geometries based on race, nationality and class.

- Awareness of the structural inequalities in securing and delivering carework in the globalizing city does not entirely obscure the possibilities of ‘cosmopolitan sociability’ (Glick-Schiller, Darieva and Gruner-Domic) to emerge in relations of care.

- While their presence in the global city raises moral anxieties not only about the shift of carework from the family to outside the home, they also alert us to the possibilities and limits of a cosmopolitan approach to care transcending boundaries of race, culture, language and nationality.
Feminist scholars have given attention to ‘the commodification of affects, emotion, and passions as they intersect more recognizable materialist analyses of globalization, gender exploitation, and wage labor in the New Economy’ (Eng).

‘Global care chains’ (Hochschild): a new ‘international division of reproductive labour’ (Parreñas), whereby women from lower-income countries migrate across international borders to provide reproductive labour (paid and unpaid) needed for the sustenance and renewal of productive labour in more advanced economies.
‘Gender transfer of filial duty from the son to the daughter-in-law, and the market transfer of elder care from the daughter-in-law to a nonfamily care worker, who is usually a woman’ (Lan).

Transnational care migration can exacerbate gender and social inequality by transferring the work of care across the international divide while leaving the sharing of carework across the gender divide uninterrogated.
This has served to perpetuate gender norms in carework, where the naturalized association of carework with women’s work depresses the status of both the careworker and the work itself.

The low value placed on caring work is not due to the absence of a need for it, or to the simplicity or ease of the work, but to the cultural politics underlying this global exchange.... The low market value of care keeps the status of women who do it – and, by association, all women – low. (Hochschild)
With plummeting fertility rates, expanding elderly populations and declining elderly dependency ratios in many more advanced economies, the eldercare deficit can no longer be contained within the family realm alone and has moved to the public sphere where care in institutionalized settings is performed largely by migrant healthcare workers.
Fertility decline is unlikely to be easily reversed, the total fertility rate having fallen from 4.66 in 1965 when Singapore became an independent nation-state, to 1.15 in 2010.

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<td>Total Fertility Rate (Per female)</td>
<td>3.07</td>
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Source: Adapted from Singapore Department of Statistics, 2011

Babies in a nursery at Mount Alvernia hospital, Singapore.
Singapore has become one of the fastest ageing populations in Asia.

Older Singaporeans constituted 7.3% of the population in 1999 and by 2030, they are expected to make up 19% of the population.
Ochiai (2010): ‘liberal familialism’, where the cost of purchasing care labour is borne by the family but where filial piety is outsourced to others whose services are bought from the market.
Transnational healthcare workers

- **Nursing homes** providing subsidised long-term eldercare depend primarily on foreign healthcare workers for the majority of their workforce.

In gearing up to meet the needs of a rapidly ageing society, the Singapore government has committed to building more than **100 eldercare facilities, including 10 nursing homes**, in neighbourhoods over the next three years (2012-2015). The creation of “hardware” will also require ramping up the recruitment of an additional **350 nurses** and **1,400 support staff** to run the 10 nursing homes.

(*The Straits Times*, 8 October 2012).
Those earning less than S$2,500 (recently increased to S$4,000) per month are not allowed to bring in their dependants.

The nationalities that dominate the workforce in nursing homes – from the Philippines, China, India and Myanmar – are more likely to be ENs and below.
RN, EN or NA?

- State plays a regulatory function by controlling the registration of nurses and midwives to maintain professional standards.

- This often results in foreign nurses having to downgrade (e.g. from RN to EN, or from EN to NA, and even in some cases, from RN to NA) in Singapore if they do not meet the criteria.

Nursing aides at the Lien Centre for Palliative Care, Singapore.
Shifting the care burden onto migrant workers employed in healthcare institutions has done little to change the pervasive discourse that caring comes ‘naturally’, is not ‘real work’ but something that carers (mainly women) do out of a sense of ‘altruism’, and hence does not need to be fully compensated.

Instead, paid carework is often perceived to be inferior in quality to care that is provided free of charge as a ‘labour of love’ by a family member, leading to the further devaluation of paid carework in institutions.
The use of migrant care workers as a means to ameliorate care deficits in the globalizing city calls into play a range of governmentality practices (categories and classifications, modes of inclusion/exclusion, etc.) aimed at controlling migrant subjects which often have the effect of undervalorising carework and stigmatising careworkers.

In Singapore, most of the enrolled nurses, healthcare attendants and nursing aides are recruited under the work permit system that not only forbids accompanying dependants but also disallows pathways to permanent residency or citizenship for the migrants themselves.

‘partial or stunted integration’? (Parreñas)
The migrant healthcare workers’ insecure foothold in the host nation-state is further made more precarious by to ‘a process of social construction that essentializes and hierarchizes them along not only national but also other intersecting dimensions’.

‘Nationality’ becomes a short-cut to judge the migrant worker’s capacity to give care, giving rise to the circulation of stereotypes:
- Filipinos are ‘warm’, ‘quick learners’ but ‘smart alecks’
- Myanmarese are ‘obedient’, ‘slow moving’ but ‘compassionate’
- Chinese are ‘competent’, ‘skilled’ but ‘lacking in compassion’.

Construction of stereotypes
While conscious of the reality of asymmetrical power geometries that shape the value of carework and careworkers, we also contend that an examination of the social relations of care can provide us with fertile ground to glimpse what Glick Schiller, Darieva and Gruner-Domic call ‘cosmopolitan sociability’:

‘consisting of forms of competence and communication skills that are based on the human capacity to create social relations of inclusiveness and openness to the world’.
Cosmopolitanism not ‘in terms of abstract moral choices’ but in terms of ‘cultural repertoires of universalism that are differentially available to individuals across race and national context’ (Lamont and Aksartova)

While it is common to think of care relationships as either hierarchical or based on notions of dependency and vulnerability, there is also space to think of forms of care-giving and care-receiving as reciprocal, interdependent and open-ended.

‘Care helps us rethink humans as interdependent beings and to consider values that guide human actions’ (Kofman&Raghuram)
Our search for cosmopolitan sociability as emergent within relationships of care does not necessarily mean masking the structural inequalities and exploitation that is embedded in the social relations of care; instead such sensibilities that can be glimpsed in the interstices of everyday life develop in spite of these structural conditions.

Offers a perspective that moves beyond ‘the binaries of inclusion vs. exclusion, sameness vs. difference’, cosmopolitan sociability highlights the possibility of ‘relationalities of openness across differences’ that may be constructed in contexts that includes ‘racialization, gender hierarchies, ethnicization, [state-imposed] exclusions and the intensified power of borders’ (Glick Schiller, Det al).
Relations of Care and Cosmopolitan Sociability: Healthcare Workers in Singapore

- Examine ways migrant healthcare workers (HCWs) ‘place’ themselves in relations of care within eldercare institutions in Singapore to discern possibilities of and limits to cosmopolitan sociability.

- **Study methods** (field research, 2007 to 2010)
  - structured survey of nurses and nursing aides (n = 412)
  - interviews with 43 migrant healthcare workers across the range of staff nurses, enrolled nurses, nursing aides and health attendants
  - interviews with 10 Singapore nurses and nursing aides.
  - interviews with half a dozen nursing home operators, hospitals with geriatric departments, as well as representatives of relevant ministries, NGOs and VWOs, the two professional nursing bodies in Singapore, and ten healthcare worker recruitment agencies.
Relations of Care and Cosmopolitan Sociability: HCWs in Singapore

- Nursing homes for the elderly as microcosms of multiculturalism at work
  - Singaporean minority, with large numbers of foreigners filling (lower) ranks of the healthcare profession

- Communication across language barriers is a daily affair
  - HCWs: largely foreigners conversant in their own languages but have differing standards and variously accented versions of English
  - Elderly residents: largely non-English speaking; often speakers of Chinese dialects (rather than Mandarin), Malay or Tamil
Social relations of care: Communication

- With colleagues:
  - “trying my best” to speak more slowly; getting “another Burmese or Sri Lankan who is better at English” to translate (Prakash, Indian healthcare attendant)

- With patients:
  - I started with sign language because I cannot express. [That was] good enough [because] these residents [were] very helpful. They also help me to pitch slowly, how to speak in Malay. ... So if you put together the dialects plus ... you have to dig and dig, and you can usually understand what they mean. So now I can speak a bit of this broken Chinese and Malay (Mavis, Filipino registered nurse)
Social relations of care: Communication

- Social relations of care: beyond the verbal
  - We can help the old people, they understand our body language [when] we help them... that’s why the old people think they like Myanmar people, [because] we go and help [using] body touch... We are patient and make them feel good” (Celine, Burmese nursing aide)

- Crossing language barriers to find common understanding present in everyday scenarios in the nursing home ➔ cosmopolitan possibilities?
Social relations of care: Family discourse

- HCWs displace racialising discourses by cultivating competencies and communication skills that open up the possibility of experiencing family-like inclusiveness within the nursing home

- Suresh (Indian healthcare attendant, 27; 2½ years in Singapore)
  - ‘Rehab’ work assisting with ambulant training for the elderly
  - Encounters with everyday racism in Singapore:
    - Chinese woman: ‘Don’t ride here, this is not your place!’ while he was on a bicycle riding along a pavement
    - Suresh: “Why are you treating us like that? I didn’t do anything. Did I do any mistake?’ So I discussed [it] with her.”
Social relations of care: Family discourse

- Felt that foreign HCWs treated less well than locals (in terms of time off; rest time; delegation of dirtier aspects of care)
- BUT made clear that feelings of discrimination had no place in the carework he performed:
  - I have a lot of patience... I am also learning a little bit Chinese, a little bit dialect, a little bit English. I like to talk to the old folks you know. I like to play with them and joke with them when [I assist them with] walking in rehab.
- Described ups and downs in his relationship with the elderly residents in terms of the ‘give-and-take’ of parent-child relationships:
  - Foreign HCWs love [and] serve [the elderly residents] like their own fathers and mothers. By loving them, they like us. ... Some can jump on you... [but] if we treat people nicely, they will also treat you nicely. That is the [relationship] we have here. Sometimes we are frustrated because we work so hard. Sometimes they [the elderly residents] call us and we ignore them. [But come] tomorrow, they will [still] call us and ask us ‘why you like that yesterday’ and I will explain to them.
HCWs develop professional competencies to deliver more effective care as pathway to creating social relations of inclusiveness in the workplace

Li Ying (PRC nursing aide, 20+; 6 months in Singapore)

Noted social prejudice against PRC Chinese amongst Singaporeans

I wanted to come to Singapore to work because I thought it would be easier to fit in [given the dominance of Chinese here]. But I think I was wrong. I think Singaporean Chinese are very different from us. They think they are superior to us and look down on us. They think we are backward and poor. You know, when a group of us from China go out together, I always feel that we are being treated badly in shops. At first I thought it was just a one-off incident but I realized that people were constantly not very friendly to us.
Bitterly disappointed her nursing diploma from China is not recognised and her job as a nursing aide is a far cry from what she had been trained to do as a nurse:

- [Here I do] everything except a nursing job. I change diapers, I bathe the patients, I take them for a walk... I think I have the capability to do much more than these ... [but] I feel I am not given enough opportunities.

Communication also a challenge

- It’s already very difficult for me to understand English but it is even more difficult to understand English in the various accents

BUT as with Suresh, Li Ying draws on the same language of ‘love’ for and ‘patience to construct social relations of care in bridging the foreign-local divide

- If you don’t like the elderly, this is not the job for you. I think the most important thing is love for elderly people... Another thing is patience.
Social relations of care: Professionalism

- Concurs with usual stereotypes of foreign HCWs (Burmese are ‘best carers’ as they are a ‘gentle and humble people’) BUT looked beyond stereotype of ‘caring’ vs ‘not-so-caring’ nationalities to articulate her gold standard for the nursing profession:
  - Just the other day, this Burmese NA was transferring this not-so-ambulant patient from the bed to a wheelchair. I think the patient was too heavy and she couldn’t support him. The patient fell heavily … [and] was groaning in pain and the Burmese NA just stood there … A Filipino NA rushed over, checked the patient’s arms and legs, and kept asking him whether he felt any pain when she pressed on his arms and legs. Then she asked me to call the doctor to check on him… You can see how calm and composed [the Filipino nursing aide] was. She knew exactly what to do. … This is what I call professionalism.

- Aspires to a sociability of shared humanity through desire to achieve high standards of professionalism (identified with competence and versatility in providing care)
Moral anxiety when caring shifts to institutionalised settings and becomes part of the public sphere
- socio-biological constructs of what constitutes the ‘family’ and ‘filial piety’ are destabilized

BUT opens up the opportunity for other kinds of social relations of care to be developed beyond the familial realm

Nursing homes as sites for the cosmopolitan possibilities as discerned from the relationalities of care between migrant healthcare workers and elderly residents amidst the ‘throwntogetherness’ (Massey, 2005) of lives lived at the multiple intersections of the local and the transnational.
Relationalities of care provide glimpses of cosmopolitan sociabilities in the making → differences normalized/bridged in the everyday attitudes of care and acts of caring for the ‘other’

- Suresh: cosmopolitan sensibilities tied to the ‘heart’ → constructed ‘others’ as part of a close-knit family through affective practices
- Li Ying: cosmopolitan dimensions associated with the ‘mind’ → caring for others best achieved through professional competencies and ethics
While cosmopolitanism can never be gender, racially or ethnically neutral, focusing on relations of care also alert us to the possibilities that common ground can be created when people are open to shared human emotions, experiences and aspirations.

In enacting ‘cosmopolitanism from below’, migrant healthcare workers contribute to reproducing the uneven contours of an ‘actually existing’ cosmopolitan city ➔ “cosmopolitanism of fragility” (Quayson)?
THANK YOU FOR YOUR ATTENTION!
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