

Migrant Care Workers in Ageing Societies:

Research Findings in the
United Kingdom

Report

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Sarah Spencer and George Leeson

June 2009

MIGRANT CARE WORKERS IN AGEING SOCIETIES

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List of Abbreviations

A8	'Accession Eight' EU member states: Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia.
ACAS	Advisory, Conciliation and Arbitration Service
ACE	Age Concern England
ADL	Activity of daily living
ASHE	Annual Survey of Hours and Earnings
CIC	Commission on Integration and Cohesion
CQC	Care Quality Commission
CRE	Commission for Racial Equality
CSCI	Commission for Social Care Inspection
DH	Department of Health
DWP	Department for Work and Pensions
EC	European Commission
EEA	European Economic Area
EHRC	Equality and Human Rights Commission
ESOL	English for speakers of other languages
EU	European Union
GAD	Government Actuary's Department
GLAS	HSBC Global Ageing Survey
GOQ	Genuine Occupational Qualification
GOR	Genuine Occupational Requirement
GSCC	General Social Care Council
ILR	Indefinite leave to remain
IRN	Internationally recruited nurse
JSA	Jobseeker's Allowance
LAWIG	Local Authority Workforce Intelligence Group
LFS	Labour Force Survey
MAC	Migration Advisory Committee

MIF	Migrants Impacts Forum
NAO	National Audit Office
NHS	National Health Service
NMC	Nursing and Midwifery Council
NMDS-SC	National Minimum Data Set for Social Care
NMS	National Minimum Standards
NMW	National Minimum Wage
NQF	National Qualifications Framework
NVQ	National Vocational Qualification
OECD	Organization for Economic Co-operation and Development
OFT	Office of Fair Trading
ONP	Overseas Nurses Programme
ONS	Office for National Statistics
PSA	Public Service Agreement
QCF	Qualification and Curriculum Framework
RCN	Royal College of Nursing
REC	Recruitment and Employment Confederation
RIES	Refugee Integration and Employment Service
SCIE	Social Care Institute for Excellence
SIC	Standard Industrial Classification of Economic Activities 2003
SOC	Standard Occupational Classification 2000
SPRU	Social Policy Research Unit
UKBA	UK Border Agency
UKCISA	UK Council for International Student Affairs
UKHCA	UK Homecare Association
WRS	Worker Registration Scheme

1. Introduction

This report explores the potential impact of an ageing population on the demand for migrant workers to provide social care for older people. It draws on new data to consider the extent to which migrants may be needed to meet an expanding demand for care services and to examine the implications for employers, older people, their families and the migrants themselves. Focusing on the UK – and in most detail on the situation in England – it reports the findings of one of four country studies conducted in parallel, between Spring 2007 and Spring 2009, in the UK, USA, Canada and the Republic of Ireland.

1.1 Background

The UK is an ageing society. The expectation that by 2030 the proportion of the population aged 80 years and over will rise to nearly 8 per cent, and the proportion aged 65 years and over to 22 per cent, has major implications for the future demand for social care services for older people. In this report we focus on the implications for the provision of social care for those older people who need assistance with essential activities of daily life in residential and nursing homes or who are living at home and receiving home care (domiciliary) services.

Long-term care for older people is still predominantly provided by family members. A long-standing government policy of favouring care in the community over institutional care has resulted in families retaining a significant responsibility for care, sometimes combined with support from formal, paid services. Within the care system, a policy shift towards ‘personalization’, including provision of ‘direct payments’ to older people from local authorities to enable them to purchase their own care, is intended to increase user choice and control over the care they receive.

Within the formal system of care provision, migrants (that is, people born abroad) comprise a significant proportion of the workforce – around 18 per cent of all social care workers in the UK as a whole and more than half in London. Some have entered the UK on work permits to work in the care system; others – including those who entered as family members, seeking refugee status or as EU citizens from central and Eastern Europe – have turned to such work subsequently. To what extent migrants will continue to be available to fill these roles, through recruitment and retention of those currently in post, or to what extent they will be replaced in the social care workforce of the future by workers born in the UK, is a key question for the future provision of social care. Predominantly female, the social care workforce will be affected

by changing rates of female participation in the labour market and their contribution to informal care. Low pay, currently close to the minimum wage, and unsocial working hours also frame the context in which the composition of the future social care workforce will be determined.

The increased demand for social care services and the cost of providing them have prompted an urgent policy debate on the future of care provision: how care should be provided, by whom, how the quality of services can be improved and how they should be funded. Improvements to the quality of care are being sought through increased levels of staff training and qualifications, regulation of care standards, and inspection of institutional provision by a regulatory body: in England, the Care Quality Commission (CQC), which took over from the Commission for Social Care Inspection (CSCI) in April 2009. The role of unpaid carers within the system has been given considerable attention, but the role of migrant workers – now and in the future – is a neglected dimension of the debate to which, prior to this study, little thought appears to have been given within or outside government. The match between policy on the entry of migrant workers and policy on the future care workforce thus arises as one focus of our analysis, alongside the implications for the future quality of care of the experiences of migrants, of their employers and of older care users.

At the same time that the future of the social care system is under the microscope, the system of entry for migrant workers has been undergoing significant reform. More than 80 categories of entry have been replaced, in 2007/8, with a five-tier ‘points system’ in which the various channels through which migrants have – directly or indirectly – entered work in the care system have been replaced with more limited options for accessing work in the UK. It is the government’s intention that vacancies in the labour market should be available first to workers already in the UK or European Economic Area (EEA), with migrant workers allowed access only where vacancies remain. A key question which this study addresses is whether, if UK and EEA workers do not meet the growing demand for social care staff, whether the new migration system will give employers access to the migrant care workers who are needed.

The challenges the UK faces are shared in other parts of Europe. A recent (December 2008) European Commission Green Paper on the future of Europe’s healthcare workforce cited demographic ageing as central to the social care challenges of the future. It identified mobility within, and to, the European Union (EU) as part of the solution, while emphasizing the importance of mitigating any negative impact of migration on the health systems of source countries (European Commission 2008).

1.2 Research questions and methods

The UK is not alone in experiencing an ageing population and a shortage of staff to provide social care for older people. This UK study has therefore been conducted in parallel to studies in the USA, in collaboration with the Institute for the Study of International Migration at the University of Georgetown; in Canada, with the Community Health Research Unit at the University of Ottawa; and in Ireland, with the Irish Centre for Social Gerontology at the National University of Ireland, Galway. For the UK study, there has been collaboration between Oxford's Centre on Migration, Policy and Society (COMPAS), which directed the project, and the Oxford Institute of Ageing; and the international team similarly brought together migration experts in the USA with gerontologists in Ireland and health and care specialists in Canada in order to ensure that expertise on the differing dimensions of the project was present within the team as a whole. The outcome of the empirical research, which to a significant extent employed the same research methodology across the four countries, is four separate country reports and a single overview report, comparing and contrasting their findings.¹

This UK study builds on a growing body of literature on the social care sector, including work by the Social Care Workforce unit at King's College London and the Social Policy Research Unit at the University of York, and reports from key bodies such as the Commission for Social Care Inspection (and its successor body the Care Quality Commission) and Skills for Care. Research on the contribution of ethnic minorities and migrants in social care has been limited (e.g. Brockmann et al. 2001; McGregor 2007; Experian 2007). Our understanding of the demand for migrant labour in the care sector has also built on the significant conceptual framework and theoretical approaches explaining the demand for migrant labour in low-paid jobs developed by Waldinger and Lichter (2003) and, for the UK, by Anderson and Ruhs (2008).

The questions which this study explored and on which we report here are:

- the factors influencing demand, in an ageing society, for care workers – and in particular migrant care workers – in the provision of care for older people in the UK;
- the experiences of migrant workers, of their employers, and of older people: in institutional care (residential and nursing care homes) and in home-based care;
- the implications of the employment of migrant workers in the care of older people for the working conditions and career prospects of the migrants concerned and for the quality of care for older people;

¹ For the Ireland report please visit <http://www.nuigalway.ie/icsg/current-projects.html>.

For the US report please visit <http://isim.georgetown.edu/pages/Research1.html>.

For the Canada report please visit <http://www.health.uottawa.ca/profs/bourgeault/Research%20Projects.html>.

- the implications of these findings for the future social care of older people and for migration policy and practice.

The potential availability of UK workers to meet future demand will be affected by a wide range of factors influencing labour supply in the care sector, including changing pay and working conditions, rising levels of unemployment and levels of welfare support, the availability of affordable childcare and the willingness of men to do care jobs. We discuss these factors (in chapter 8) but an assessment of their impact is beyond the remit of this study.

To achieve the objectives of the study, three primary research strands were developed around (1) migrant care workers, (2) older adult care users and (3) employers. Primary data gathered by the research team focused on the workforce providing care for older people: this means that our evidence is complementary to most data available for the care sector, which refer to the whole range of adult care services.

In developing each of the investigation strands careful consideration had to be given to the international comparative element of the research. The scope and scale of the pre-existing data and the accessibility and depth of information sources had to be assessed. These preliminary assessments contributed to a comparative strategy that provided an optimal basis for analysis.

The level of demand for care is shaped not only by ageing trends but also by the preferences of older people and their families in relation to the nature of the care provided and to care givers. Choice is constrained by the rationing of care provision where an official assessment of need determines access to publicly funded provision, and by the personal resources of care users and their families. Assessment of demand for care thus incorporates both quantitative measures of need and qualitative determinants. This duality was reflected in our combination of quantitative and qualitative methodology in this study, which included both a macro and a micro level of analysis. Combining these techniques as a part of the study design was also complementary to the multidisciplinary scope of the research, which includes aspects of migration, ageing, and health and social care.

The research consisted of the following five main pieces of data collection and analysis:

1. Analysis of existing national data sources on the social care workforce in the UK, with a specific focus on the migrant workforce. This was largely based on the Labour Force Survey (LFS) but drew also on other major statistical sources, including the National Minimum Data Set for Social Care (NMDS-SC).
2. A postal and online survey of 557 employers of social care workers, carried out between January and June 2008, including residential and nursing homes and home care agencies

providing care services to older people. This was followed up by 30 in-depth telephone interviews with selected respondents.

3. In-depth, face-to-face interviews, carried out between June and December 2007, with 56 migrant care workers employed by residential or nursing homes, home care agencies or other agencies supplying care workers, or directly by older people or their families.
4. Five focus group discussions, carried out between December 2007 and March 2008, with 30 older people, including current users of care provision (residents of residential care homes and home care service users) and prospective care users (members of community groups for older people).
5. Projections of future demand for migrant care workers and nurses in older adult care.

Details of the methodology can be found in the appendices.

A series of background components were included in the methodology to inform the design of the data collection instruments, and to provide contextual information. Background papers on the adult social care workforce (Moriarty 2008) and the structure of the health and social care systems (Howse 2008) were commissioned from experts in these areas. Briefing papers informing the research about key issues surrounding care workers' migration from a source country perspective were also prepared, focusing in particular on recruitment. These were based on a review of the existing evidence and interviews with key informants in Poland, Jamaica and the Philippines.

Prior to the research commencing, a series of discussions were held with individuals and organizations working in the field as policy makers or practitioners and in academia. An international advisory group met twice during the course of the research and its members provided feedback on the draft report – see appendix 6.

1.3 Definition of terms

It is necessary to be clear what meaning we attach to key terms used in this report, terms whose definition is in part determined by the availability of differing data sources.

In our use of the term 'migrant' we refer, unless otherwise stated, to those born outside the UK, that is, foreign born. This reflects the greater availability of data in the UK based on country of birth rather than on, for instance, nationality. By 'recent migrants', of which there is no official definition, we refer to those who have arrived in the UK since 1998.

We use the term ‘care worker’ to refer to staff who directly provide care including senior care workers and care assistants working in residential and nursing homes; home care workers employed by home care agencies; other agency workers; live-in and domestic care workers employed directly by older people or their families. Not included within ‘care workers’ are professional staff such as nurses, social workers and occupational therapists. Unless clearly referring to all care workers (which can be necessary where the data make no distinction), we are referring to those care workers providing direct care to older people rather than, for instance, providing care to disabled people or for children. Where possible we draw a distinction among care workers between senior care workers and care assistants.

We use the term ‘older people’ to refer to those aged 65 and over, and the term ‘older old’ to refer to those aged 80 and over.

1.4 Structure of the report

In the next two chapters of the report we provide a contextual overview of policy and practice in the formal and informal provision of health and social care for an ageing population in England or the UK as a whole. (Chapter 2), going on to examine migration policy and practice as they relate to this sector, including policy on the reception of newcomers and their employment rights (Chapter 3). Chapter 4 provides an analysis drawn from existing national data sources on the migrant social care workforce – including gender, age profiles, countries of origin and regional distribution in the UK, as well as data on pay and working hours – before drawing on our own survey of employers to supplement this evidence with data on migrant care workers who are looking after older people.

Chapter 5 continues to draw on our survey of employers alongside evidence of migrants’ experiences to consider the recruitment and retention of migrant workers. It explores the reasons behind employers’ difficulty in recruiting UK born workers, notes the differing methods of recruitment they use, and identifies the advantages and challenges they say they experience in employing migrants, including significant issues for both employers and migrant workers relating to the operation of the immigration system.

In chapter 6 we draw on the employer survey, interviews with migrant workers and focus groups of older people to explore the full range of issues relating to quality of care, including older people’s perceptions of a ‘good carer’, the essential qualities of a care relationship, the challenges posed by language limitations and broader communication barriers, and the impact of the conditions in some care homes, including staff shortages, on this relational quality of care.

In chapter 7 we explore the challenges experienced by migrant care workers in relation to discrimination and access to employment rights, both within institutional care and in home care – experiences which also have implications for older people as care users and as employers. Our findings here are among the significant challenges which we suggest, in the final chapter, need to be addressed in policy and practice reform.

In chapter 8 we set out our projections of demand for migrant care workers, in the form of a low, a medium and a high scenario. Finally, in the concluding chapter, we summarize our findings and set out some implications for future social care and migration policies.

When reporting the findings of the interviews and focus groups in the following chapters, the names of any individuals we refer to have been changed to protect their anonymity.

2. Policy and Practice in the Provision of Social Care for Older People

This chapter sets out current policy and practice in the provision of social care for older people and considers the potential implications of an ageing population among the factors influencing future provision.² It begins by contrasting health and social care provision before exploring the differing formal and informal means of delivering care to older people, the public and private means through which care is funded and provided, the main characteristics of the social care workforce, and issues relating to its pay and working conditions. It summarizes data demonstrating the ageing of the UK's population and considers the implications of, and broader policy debates on, the challenges of meeting demand for care and of securing improvements in the quality of provision. The chapter focuses on provision in England, to which much of our evidence and data relate.

2.1 Provision of social care for older people

The provision of publicly funded health and social care services in the UK is divided between *healthcare* provision, the responsibility of the National Health Service (NHS), and *social care* provision, the responsibility of local authorities. In practice there is often a blurring of health and social care needs (Moriarty 2008) and a need for joint working between services (DH 2005b). Social care for older people largely refers to the provision of *long-term care* for people who need help with essential activities of daily living, including personal care and domestic tasks. It includes institutional care in residential and nursing homes, and community care for people living at home and receiving home care services.

2.1.1 Informal care

Most long-term care for older people is still provided informally, usually by family members. Around 1.7 million older people in the UK are receiving informal care from relatives and/or friends providing unpaid help with everyday tasks. In recent years, families have taken significant responsibility for the care of older people (see e.g. CSCI 2008). Older people with the kinds of care needs that would previously have triggered a move to institutional care are increasingly being cared for at home (a trend that followed the introduction of the 1993

² This chapter includes edited sections of two background papers commissioned for the research: *The health and social care system in the UK* by Kenneth Howse (2008) and *The social care workforce in the UK labour market* by Jo Moriarty (2008). We acknowledge with gratitude these contributions to our research.

community care reforms), often by a family member, sometimes by formal services, and sometimes by a combination of the two. Therefore, the future availability of unpaid informal care from family and friends is one key factor influencing future demand for formal services.

2.1.2 Formal care

Older people are the main users of healthcare services in the UK, as in most European countries, and their use of at least some forms of health service provision has been increasing over time. In 2003/4, 43 per cent of all NHS spending on 'hospital and community health services' was allocated to people aged 65 years and above (Howse 2008).

In its penultimate report on *The state of social care in England 2006/07* CSCI (2008) estimated that just under 1.1 million older people used social care services in 2006 (out of an estimated 2,450,000 older people with care needs). 317,000 (about 4 per cent of the overall older population, 13 per cent of those with care needs) were receiving institutional care in residential or nursing homes or long-stay hospitals, and 751,000 (just above 9 per cent of the population aged 65 and over, 31 per cent of those in need of care) received home based care.

Unsurprisingly use of social care is much higher among the 'older old': for example, the proportion of older people living in care institutions at the last census (2001) was 11.0 per cent among those aged 80 and over, compared to 1.3 per cent in the 65-79 age group. The increasing longevity of the population therefore has implications for the increased use of long-term care services: survival into late old age carries a higher risk of dependency on intensive, and more costly, long-term care services.

There is evidence of considerable unmet need in the provision of formal social care services to older people. CSCI (2008) estimated that the number of older people receiving support through formal provision in England has declined as a result of local authorities tightening eligibility criteria, leaving those who do not qualify for publicly subsidized services and cannot afford to fund their care themselves with only informal support. Even taking into account the support of family carers, CSCI's estimates suggest that about 450,000 older people (most of them with moderate and lower care needs) have some shortfall in their care provision. The inability of the social care system to meet existing demand for provision must raise significant concerns when considering rising demand in the future.

Like many European governments, the UK government is committed to shifting the balance of formal provision for older people with relatively high levels of dependency – and so in need of intensive support – away from institutions to home-based care. Most older people say they want to stay in their own homes for as long as possible; and the government wants the number of frail older people being supported in their homes to be the maximum compatible with safe

and appropriate care (Howse 2008). In *Putting people first: a shared vision and commitment to adult social care* the government set out its intention to enable people 'to have maximum choice, control and power over the support services they receive' (DH 2007b: 2).

2.1.3 Funding of social care

Publicly funded health care (including hospital-based and community nursing services as well as nursing care provided in care homes) is 'free at the point of delivery' for all UK residents and is funded almost entirely by the state out of general taxation. Access to health care determined by clinical need, and not by the ability to pay, is generally regarded as the core principle of the NHS. More than 80 per cent of total health care expenditure comes from public funds, a proportion that has been increasing over recent years (NAO 2003). Although the NHS has been subject to successive market-based reforms, the scale of private sector involvement in the healthcare system remains small,³ and UK residents are still served by a national network of publicly owned hospitals staffed by healthcare professionals who are public employees.

By contrast, access to publicly funded social care is means-tested as well as needs-tested in England, Wales and Northern Ireland (but not in Scotland, where the personal care element of care provision is free), and a far greater proportion of the total costs of long-term care services is met by private means than is the case in the healthcare sector.

In 2007/8, the gross current expenditure for care and support in England was estimated to be £20.7 billion, 4 per cent of total government expenditure; of this, £8.8 billion (42 per cent) was spent on older people. In real terms (i.e. after adjusting for the change in prices), gross expenditure for older clients has increased by 7 per cent relative to 2003/4, but decreased by 2 per cent relative to 2006/7 (Information Centre for Health and Social Care, 2009).

Local authorities have been responsible for assessing the eligibility of older people for publicly funded provision. In the case of institutional care, the financial criteria for assessing eligibility for means-tested support are determined by national rules.⁴ In the case of home care services, local authorities have determined their own criteria.⁵ Budgetary pressures have led to the rationing of publicly funded social care, particularly of home care services, and local authorities are increasingly directing their cash-limited budgets towards older people with higher dependency and consequently greater needs. It has become much harder for older people with lower levels of dependency to secure publicly funded home care (Means et al. 2002). Data from

³ By the standards of OECD countries with public contract models of provision (Howse 2008).

⁴ Scotland operates a different set of rules from the rest of the UK.

⁵ This has led to geographical inequalities in access to publicly funded provision (Howse 2008).

the CSCI show that local authority rationing of care for people whose needs are deemed 'substantial' has risen significantly in recent years.⁶

Representatives of private social care providers argue strongly that the fees paid by the state do not reflect the cost of care provision, and that view has repeatedly been endorsed by the Low Pay Commission. It notes in its 2009 report on the National Minimum Wage that the most recent Laing and Buisson survey of local authorities (2008) found that the increases in sums paid by the majority of local authorities to those running care homes did not even meet cost inflation; and the Commission's own survey of employers found that in two-thirds of cases attempts by social care providers to renegotiate contracts following the October 2007 increase in the National Minimum Wage were unsuccessful. In 2007/8 the average unit cost of 'in-house' local authority homecare was £22.30 but the average cost to local authorities when using independent care providers was only £12.30 (UKHCA 2009: 7). The Low Pay Commission states, 'we continue to be concerned by the shortfall in funding experienced by many social care providers,' and recommends that 'the commissioning policies of local authorities and the NHS should reflect the actual costs of care, including the National Minimum Wage' (Low Pay Commission 2009).

Data on private expenditure for social care is limited. CSCI estimated that in 2006 total costs for older adult services borne by private households – including top-ups and charges paid by those partly funded by local authorities – was about the same as the public expenditure. However, the proportion of privately funded services was significantly higher in residential care than in home care – 57 per cent and 38 per cent respectively (CSCI 2008: 116).

The question of who pays for care – the state (funded by taxation), the individual and/or the family – and the 'balance of responsibility' between these groups, continue to be central to government policy debates regarding the future of care for older people. A consultation paper in 2008 subtitled *Care, support, independence: meeting the needs of a changing society* set out options for the future funding of a '21st century care and support system' and further proposals are expected during 2009. Increasing longevity and an ageing population have implications for the future affordability and sustainability of the long-term care system. These budgetary pressures, as we shall see, raise issues for the future of care not only in terms of access to services for older people, but also in terms of the staffing of the sector (the expansion of the social care workforce), the pay and conditions of social care workers, and the quality of care services provided.

⁶ Carvel (2007); DH (2008).

http://collections.europarchive.org/tna/20081105165041/http://www.csci.org.uk/pdf/FACS_2008_03.pdf

2.1.4 Private and public sector care providers

A 'mixed economy' of providers of social care has developed, with the private sector involved in the delivery of services to a much greater extent than is the case for healthcare. There has been a huge shift (particularly marked in England) in the provision of home care services away from local authority providers to the private and third sectors,⁷ which together now provide services to around two-thirds of all households receiving publicly subsidized home care (Wanless 2006). According to the Laing and Buisson's dataset of care institutions (2007), 78 per cent of places in residential and nursing homes having older people as their primary clients were in the private sector, 14 per cent in the third sector and 8 per cent under the direct management of local authorities. Although local authorities thus do retain some residual capacity for both types of provision, their main responsibility now is to 'facilitate' the distribution of public funds by purchasing services from the private and third sectors and to assess the eligibility of older people for publicly funded provision.

As we shall see in section 2.3, the contracting out of services to the independent sector means that only a minority of social care workers are now employed in the public sector by local authorities. Current and future demand for care workers, and for migrant care workers specifically, therefore predominantly concerns demand for migrant labour by private sector providers.

In 2006/7 there were around 35,000 separate establishments providing social care in England, including 22,300 care homes and 7,400 CSCI-registered domiciliary care and nursing agencies. 58% of all establishments (20,200) had ten or fewer employees, and a further 10,200 (29 per cent) had 11–49 employees (Eborall and Griffiths 2008). Based on the Laing & Buisson's data set of care homes and nursing homes (2007), 57% of institutional care providers across the UK have older people as their primary service users.

The last decade has seen some closures among small, privately owned residential homes (Netten et al. 2002), in part as a result of the availability of better home-based services, assistive technology, and specialist extra care housing (DH 2005b). However, the number of nursing homes is remaining stable, and their capacity slightly increasing (CSCI 2009). There has also been a rise in the number of large corporate providers, including multinationals (Drakeford 2006), leading to the invention of the word 'caretelization' (Scourfield 2007: 156). Just over 50 per cent of private care homes with nursing are now operated by large companies (Eborall and Griffiths 2008). This pattern, whereby the contracting out of care services is followed by consolidation of the labour market, with concentration under a few providers (Schmid 2003), can also be discerned in other countries (Lethbridge, 2005).

⁷ Third sector: not-for-profit and voluntary organizations.

In June 2008 there were 4,960 home care agencies registered in England, of which 84 per cent were in the private and voluntary sectors (UKHCA 2009). Local authorities are the main purchasers of home care, accounting for some 80 per cent of the care purchased. According to the UK Homecare Association (UKHCA),⁸ 60 per cent of independent providers rely on local authority purchase for more than three-quarters of their business, with almost 15 per cent having local authorities as their only customer. This reliance on public sector funding in the home care and residential sector is highly significant in relation to wage levels in the sector, and to reliance on migrant workers, issues to which we shall return in chapter 4.

2.2 User choice and the personalization agenda

The introduction of mechanisms to promote users' choice of and control over the care they receive has been a central component of public service reform in the UK (and other OECD countries), with the aim of making service provision more responsive to the needs of service users. The expansion and regulation of the market of providers, and the improvement of information available to people trying to choose a care home or other services for themselves or a relative, are both essential to promoting choice and control (Howse 2008), an objective referred to as 'personalization'. The Equality and Human Rights Commission has recently affirmed the importance of empowerment of care users to direct their own care (EHRC 2009).

The main focus of policy in this area has to date been the implementation of 'cash for care' schemes, including direct payments from local authorities to those in need of care, extended to people aged 65 and over in 2000. Direct payments give older people the option of a cash payment with which to purchase their own care (Poole 2006). Similar schemes are operated in the US and in other parts of Europe (Doty et al. 2007; Ungerson and Yeandle 2006; Simonazzi 2009). This approach coincides with the preference by older people for home-based care provision.

The uptake of direct payments was initially low, despite a mandatory requirement for local authorities to offer this option to all users where possible, and the inclusion of indicators on levels of uptake in performance monitoring of adult social care (Moriarty 2008). In England, the proportion of net expenditure on community services spent on direct payments was 7 per cent in 2006/7, up from 2.5 per cent in 2002/3 (CSCI 2009). As of March 2008, 55,900 adults, including older users, received direct payments to fund their care needs. This compares with 40,600 in March 2007 and 32,200 one year earlier (CSCI 2009)⁹. Older people account for about

⁸ UKHCA (2009), drawing on NHS (2008) and CSCI (2008b).

⁹ Per capita average annual net expenditure for older people receiving Direct Payments increased in real terms from £5,100 in 2005-06 to £5,400 in 2006-07 (CSCI 2009).

1 in 3 recipients. In 2008 there were in addition about 2,500 recipients in Scotland (National Statistics 2008), 2,000 in Wales (Welsh Assembly Government 2008) and 1,100 in Northern Ireland (Department of Health, Social Services and Public Safety 2008). Rates of uptake in England are rising and are more than double those in other UK countries, reflecting both local implementation factors (e.g. varying eligibility for social care services between the countries of the UK and the local authorities within them) and differences in the organization of social care systems (SCIE 2009). Skills for Care foresees use of direct payments rising rapidly in future years (Eborall and Griffiths 2008).

Barriers to uptake for older people include the practical difficulties and anxiety involved in taking on the responsibility for finding their own carers; the 'additional burden' and risks of organizing their carers' employment (SCIE 2007; Glendinning et al. 2008); and the fact that the payments are usually low relative to the cost of employing a carer – a mean weekly value of £230 for older people (Glendinning et al. 2008). Nevertheless, the extension of 'cash for care' schemes remains central to the government's agenda for the personalization of social care (DH 2005b, 2006b).

In addition to direct payments, 'individual budgets' for care are currently being piloted. In this scheme, the care user is offered a combined budget for social care and other support (such as equipment). The user can then choose to take a service, cash, or a combination of the two, spending their budget on any reasonable means to enhance their well-being, including a wider variety of paid workers than would be eligible under direct payments. In *Putting people first* (DH 2007b) the government made a commitment to shift to this approach for all adults eligible for social care. Analysis of the priority given by local authorities to the extension of direct payments and individual budgets for care shows that 80 out of the 150 largest authorities selected progress on this issue as a priority on which they wanted their performance to be assessed.¹⁰

While direct payments and the development of individual budgets are widely welcomed, there are concerns. An evaluation of the individual budget pilot programme found that there was no means of ensuring Criminal Record Bureau checks on people employed directly by budget holders (Glendinning et al. 2008). Others have expressed concern that local authorities are allocating less funding to users to purchase their own care than they would have allocated if councils had provided the services themselves; that the administrative cost to agencies of providing care to separate individuals will be greater, reducing the resources available for care

¹⁰ Correspondence with the Government Equality Office on the status of key local government indicators that have an impact on delivery of Public Service Agreement (PSA) 15 (Equality), referring to Department of Health (DH) National Indicator 130, Dec. 2008.

provision; and that expansion of provision at home will mean fewer care homes and hence less choice for those who need that form of care (Cole 2008).

The introduction of direct payments, enabling older people to become the purchasers of their own care and to employ their carers directly if they choose to do so, has also led to a blurring of the boundary between service user and employer, with potential repercussions on employment relationships between social care workers and the older people for whom they care.¹¹ Trade unions are concerned that the introduction of direct payments and individual budgets in the context of local authority funding shortages has led to potential for exploitation of vulnerable workers: a survey by UNISON of personal assistants (employed under the individual budget arrangements) found concerns relating to pay, sick pay, lack of pension provision, split shift working and recruitment methods. 'There is a growing danger of a casualisation of the workforce, a slide into the informal economy, no questions asked and no tax or national insurance paid' (Pile 2008). Similarly, the Low Pay Commission is concerned that direct payments may be making it more difficult to ensure awareness of and compliance with the National Minimum Wage, and has urged the government to consider how it can rectify this (Low Pay Commission 2009: paras 3.3.7–3.3.8).

2.3 The social care workforce

Social care for older people mainly relies on two broad types of worker: a 'direct care' workforce providing regular support (including care assistants, home carers and support workers); and professional staff (nurses, social workers, occupational therapists and other staff with care-related professional qualifications). In addition, workers are employed in managerial, administrative and ancillary roles. The introduction of 'cash for care' schemes has led to the development of workers with new functions among the direct care workforce, such as personal assistants working with people receiving direct payments (Ungerson 1999; 2003).

The overall social care workforce (including direct carers, professional staff, managers, administrative and support staff, etc.) constitutes around 5 per cent of the total UK workforce: a smaller proportion than that found in some other EU countries, such as Denmark and Sweden, but higher than that found in others, such as Spain or Hungary (van Ewijk et al. 2002: 69). Its importance to the UK labour market has only been recognized comparatively recently. The statement in the 1998 White Paper *Modernising social services* (Secretary of State for Health 1998: para. 5.1) that the social care workforce numbered more than a million people,

¹¹ The work of Ungerson (e.g. Ungerson and Yeandle 2006) has focused on the impact of direct payments in this respect.

and thus was similar in size to that employed in the NHS, came as a surprise to many outside the sector (Moriarty 2008).

The advent of the National Minimum Data Set for Social Care (NMDS-SC) collecting data from the public, private and third sectors, has significantly improved the evidence base on the social care workforce in England (Skills for Care, 2007a). However, there are still deficiencies in the data (for further discussion see Beesley 2006; Moriarty 2008), the most important of which for the aims of our study is that data on migrant workers is currently unavailable from the NMDS-SC because neither nationality nor country of birth is recorded.¹² Comparison of estimates of the social care workforce in the four UK nations is also problematic because of differences in the way information is categorized and recorded in other data sources (see Moriarty 2008: 7). The data below therefore refer primarily to the workforce in England.¹³

2.3.1 Numbers and structure

Table 2.1 shows Skills for Care's most recent estimates of the size of the social care workforce, published by CSCI. In 2007/8 there were 1.5 million jobs in adult social care in England (CSCI 2009)¹⁴ – an increase of more than 100,000 from the previous year. 1.41 million were directly employed at their place of work and 93,000 were bank, pool or agency staff.¹⁵ The directly employed workforce includes an estimate of the number of home care workers employed by adults receiving direct payments, but excludes those directly employed by people who are not receiving any public support and paying entirely for their home care.¹⁶

¹² At present, the NMDS-SC only includes information on workers recruited abroad. As we will show in the following chapters, this is a small subset of the migrant workforce because the majority of migrant carers enter the UK through non-labour immigration channels and/or are recruited locally. In order to improve capacity of the NMDS-SC to collect information on the migrant workforce, a national consultation was carried out by Skills for Care at the beginning of 2009 concerning the proposal to introduce questions on country of birth, nationality and year of entry. As respondents expressed a high level of support for the proposed changes, Skills for Care decided to pilot the three questions; if this pilot scheme is successful, the changes will be implemented in full from September 2010 (Skills for Care 2009b).

¹³ See Moriarty (2008) regarding available data for all four UK countries.

¹⁴ Estimates from the LFS suggest that the social services workforce in Scotland numbers 138,000 people. In Wales, the workforce is estimated to be 88,773 people, and in Northern Ireland, 40,140 people (for further details see Moriarty 2008: 9).

¹⁵ This estimate does include some degree of double counting in that people may have more than one job in social care. Furthermore, many work part-time and the available information is often insufficient to transform these headcounts into whole/full-time equivalents (WTEs/FTEs) (Moriarty 2008).

¹⁶ Beyond some small-scale research some time ago (Baldock and Ungerson 1994), little has been done to quantify the workforce employed directly by people funding their own care or by their families. The tightening of eligibility

TABLE 2.1: ESTIMATED SIZE OF THE ADULT SOCIAL CARE WORKFORCE IN ENGLAND, HEADCOUNT IN JOBS^a, 2007/8

	<i>Private</i>	<i>Voluntary</i>	<i>Local authority^b</i>	<i>NHS^c</i>	<i>Direct payments</i>	<i>Total</i>	<i>% of total workforce</i>
Residential care	456,000	129,000	50,000	–	–	635,000	42
Domiciliary care	271,000	35,000	44,000	–	152,000	502,000	33
Day care	8,000	32,000	27,000	–	–	67,000	4
Community care ^d	22,000	35,000	90,000	62,000	–	208,000	14
<i>Total directly employed</i>	<i>757,000</i>	<i>231,000</i>	<i>210,000</i>	<i>62,000</i>	<i>152,000</i>	<i>1,413,000</i>	<i>94</i>
Not directly employed ^e	48,000	34,000	11,000	n/a	n/a	93,000	6
<i>Total workforce</i>	<i>805,000</i>	<i>265,000</i>	<i>221,000</i>	<i>62,000</i>	<i>152,000</i>	<i>1,505,000</i>	<i>100</i>
<i>% of total workforce</i>	<i>53</i>	<i>18</i>	<i>15</i>	<i>4</i>	<i>10</i>	<i>100</i>	

^a Because of rounding, individual components may not sum to totals.

^b The allocation of the workforce employed by local authorities between adults' and children's services is that used by LAWIG/LGA in its 2006 Adult Social Care Workforce Survey and is likely to include some staff working wholly or mainly in children's services.

^c NHS estimate includes healthcare assistants but not support workers, nursing assistants and helpers except in social services and occupational therapy areas.

^d Including NHS and the organization and management of care in local authorities and the community.

^e e.g. agency, 'bank' staff and students.

Source: CSCI (2009: 104). Estimates by Skills for Care based on NMDS-SC and other sources.

Less than a fifth of the total workforce is employed in the public sector (local authorities and NHS) while the private sector is by far the main employer (53 per cent of the workforce). In terms of trends, the independent sector (private + voluntary) absorbed most social care jobs created over the previous year (+82,000). In contrast, the local authority care workforce has contracted by 7,000 jobs (down from 228,000 in 2006/7).

152,000 care workers were estimated to work for (but not necessarily were employed by) individuals receiving direct payments. Over the most recent years this workforce has been the fastest-growing component of the social care workforce in relative terms (a rise of 35 per cent relative to 2006/7). However, little is known about the characteristics of this workforce. There is evidence that older people may be less keen than other care users to take on this responsibility.

The proportion of people employed as temporary workers ('not directly employed' in table 2.1) in social care appears to be relatively small (6 per cent of the workforce). However, it is difficult

criteria for publicly funded social care means that there is potentially a larger market of employers among older people self-funding their care (145,000 in 2006), but virtually no data is available (Eborall and Griffiths 2008).

to discern from workforce data for social care how many flexible or agency staff are used, as these workers are rarely included and where they are included data are of poor quality (Beesley 2006).¹⁷ Some groups may be over-represented among temporary workers. It has been suggested that people from minority ethnic groups are over-represented among those employed on a temporary basis in social care (Conley 2003), and that migrant workers are over-represented among agency workers overall (Jayaweera and Anderson 2008).

A comprehensive breakdown of the workforce for 2006/7 is available in Skills for Care's report on the state of the adult social care workforce in England (Eborall and Griffiths 2008). Making allowance for the element of double counting arising from the fact that a significant proportion of workers hold more than one care job, Skills for Care estimates at 1.15 million the number of actual individuals in the total workforce in 2006/7 – against a headcount of 1.39 million in jobs, and excluding workers directly employed by individuals privately purchasing care (Eborall and Griffiths 2008).

Table 2.2 sets out the breakdown of the directly employed workforce by main job role. It shows that in 2006/7 workers in direct care roles made up nearly 70 per cent of the sector's workforce, with an estimated 764,000 care worker's jobs¹⁸. Other occupational groups are much smaller – 131,000 jobs are in managerial roles, 90,000 in professional roles (including nurses, social workers and occupational therapists) and 184,000 in administrative and ancillary positions.

Detailed estimates of the distribution by job role have not yet been published for 2007/8, but on the basis of the abovementioned increase in the workforce over the past year it can be assumed that there are currently about 850,000 care worker's jobs in the directly employed workforce in England – and over 900,000 if agency and 'bank' staff and students are considered. As mentioned above, this estimate excludes home care workers directly employed by individuals privately purchasing care.

Care workers' distribution across the care sector shows that just three quarters of them are employed by the independent sector, 11 per cent by local authorities and the rest (about 15 per cent) by individuals receiving direct payments. It has to be noted that care workers account for a much higher share of the care workforce in the independent care sector (62 per cent) than within local authorities (38 per cent).

¹⁷ 'Flexible staff' is defined as 'any sort of staffing which falls outside the norm of employment for an unspecified term on fixed basic full-time or part-time hours' (Laing and Buisson 2004, cited in Beesley 2006: 6).

¹⁸ The other main occupational category classified under the direct care workforce in the NMDS-SC cross-tabulations is 'Community support and outreach workers'.

TABLE 2.2: STRUCTURE OF THE DIRECTLY EMPLOYED ADULT SOCIAL CARE WORKFORCE IN ENGLAND, HEADCOUNT IN JOBS^a, 2006/7

Type of job role	Independent sector	Local authority ^c	NHS ^d	Direct payments	Total	% of directly employed workforce
Management and supervisory	94,000	37,000	1,000	–	131,000	10
Professional ^e	52,000	21,000	17,000	–	90,000	7
Direct care/support	644,000	107,000	42,000	113,000	905,000	69
<i>of which: care workers</i>	<i>569,000</i>	<i>82,000</i>	<i>?</i>	<i>113,000</i>	<i>764,000</i>	<i>58</i>
Others (admin., ancillary, etc.)	131,000	53,000	n/a	–	184,000	14
<i>Total directly employed</i>	<i>921,000</i>	<i>217,000</i>	<i>60,000</i>	<i>113,000</i>	<i>1,311,000</i>	<i>100</i>

^a Because of rounding, individual components may not sum to totals.

^b Private and voluntary sectors combined.

^c The allocation of the workforce employed by local authorities between adults' and children's services is that used by LAWIG/LGA in its 2006 Adult Social Care Workforce Survey and is likely to include some staff working wholly or mainly in children's services.

^d NHS estimate includes healthcare assistants but not support workers, nursing assistants and helpers except in social services and occupational therapy areas.

^e Including nurses, social workers and occupational therapists.

Source: Eborall and Griffiths (2008: 28).

As mentioned above these figures refer to the number of jobs in all social care in England. In order to estimate the number of *individuals* working as care workers in *care for older people across the UK* we build on Skills for Care estimates for 2006/7 and use additional data from the NMDS-SC and the LFS. Based on the methodology set out in appendix 4, we obtain an estimate of 642,000. We also estimate at 60,000 the number of nurses working in long-term care for older people in 2006/7. These estimates are then used as base-year numbers of care workers and nurses in our projections of the workforce caring for older people to 2030 (see chapter 8).

2.3.2 Age, gender and ethnicity

We compare the demographics of the UK born and migrant care workforce in chapter 4; here we look more broadly at the age, gender and ethnicity of the social care workforce as a whole.

Unless otherwise specified, estimates in this section are based on NMDS-SC cross-tabulation of data collected up to 31 December 2008.¹⁹

Possibly the most striking feature of the social care workforce is its horizontal and vertical gender segregation.²⁰ According to NMDS-SC data, women are estimated to constitute around 85 per cent of the social care workforce, with even higher proportions among care workers (88 per cent), senior care workers (88 per cent) and registered nurses (89 per cent). However, women make up a smaller proportion of senior managers (71 per cent). The overall ratio of 4:1 in favour of women is consistent across the UK (Department of Health Social Services and Public Safety 2006; Scottish Executive 2006b; Care Council for Wales n.d.).

While the huge gender imbalance is rooted in the traditional perception of care jobs as low-status, low-paid and 'women's work', a closer look at NMDS-SC workforce data discloses interesting patterns behind the gender differentials. For example, a breakdown by type of employment shows that part-time work is less attractive to men, whose share in the full-time workforce (19 per cent) is twice as high as that among part-time workers (9 per cent). Men also make up a higher proportion of workers within micro employers (fewer than 10 employees), and a lower percentage in domiciliary care – which may again be related to the part-time/variable hours nature of such work, as well as to a preference on the part of users for female care workers in this role (Skills for Care 2008b). The gender breakdown of the workforce by year first worked in the care sector shows that the sector may be beginning to attract more male workers: one in five of those who joined in 2005/6 were men – with a higher proportion (31 per cent) found among recent migrants (see section 4.6). However, it is too early to say whether this is a sustainable trend which will contribute to redressing the gender imbalance (Skills for Care 2008b).

Like its counterpart in healthcare, the social care workforce is often described as an 'ageing workforce' (McNair and Flynn 2006), raising issues for the future staffing of the sector. However recent data and analysis suggest that this is less a concern than previously thought, as there is no clear evidence that this is in fact the case (Eborall and Griffiths 2008). People of all ages work as care workers. When NMDS-SC age data are compared with the age structure of the overall workforce estimated by the Labour Force Survey (LFS), no significant difference emerges. Roughly speaking, out of every six care workers two are aged below 35, three are between 35 and 54 and one is 55 or older. Nevertheless, there is evidence that local authority workforces

¹⁹ The standard NMDS-SC cross-tabulations and statistics available at the end of 2008 have been produced by analysing data on over 21,500 establishment records and over 260,000 worker records. They can be accessed at www.nmds-sc-online.org.uk.

²⁰ Horizontal segregation is used to describe the tendency for women to be in different jobs or occupations from men. Vertical segregation means that, within a particular occupation, women tend to hold the lower-status and less well-rewarded positions.

tend to be older and are possibly ageing overall (Eborall and Griffiths 2008). For example, over 40 per cent of home care staff employed by local authorities in England are aged 50 or above (LAWIG 2006).

Interestingly, 57 per cent of workers do not start working in social care until they are aged 30 or over, and one in ten join the social care workforce in their fifties (Eborall and Griffiths 2008). Skills for Care research has suggested that there may be reasons for social care being attractive to older workers, such as flexibility of hours or a higher interest in the nature of the work (Skills for Care 2008b).

Labour market patterns related to ethnicity are also evident. Some ethnic groups are over-represented within the social care sector relative to the overall workforce. NMDS-SC data suggest that non-white minority ethnic groups account for 17 per cent of care workers (including both UK and foreign born workers). This may be an underestimate because of the relatively high number of missing responses. Black or Black British (i.e. UK born black) workers are strongly over-represented in the direct care workforce, making up one out of two non-white carers, i.e. approaching 10 per cent of all care workers: a proportion three times as high as their share of the overall UK workforce. Interestingly, the proportion of British minority ethnic (BME) workers is much higher among nurses working in nursing homes – 44 per cent, among whom Asian or British Asian nurses form the largest group. Staff from minority ethnic groups are not evenly distributed across sectors and regions. There is a particularly strong concentration of BME social care workers in London, where they constitute two-thirds of the workforce. BME staff are more often found in the private sector and in medium and large business. It has also been suggested that people from minority ethnic groups are over-represented among those employed on a temporary basis in social care (Conley 2003).

2.3.3 Pay

Social care is identified as one of the sectors of the UK economy where low pay is common (Low Pay Commission 2005), notwithstanding the fact that direct care workers were one of the groups to benefit most from the introduction of the National Minimum Wage in 1999, and social care employers were among those most concerned about its impact (Grimshaw 2002; Grimshaw and Carroll 2006). Low pay of the care workforce reflects a historical undervaluing of women's work and a high degree of gendered occupational segregation and part-time work (Moriarty 2008).

Labour costs make up a significant proportion of the running costs of care providers. Care workers' wages account for half the costs of providing home care and between half and two-thirds of the costs in care homes (Wanless 2006: xxv). This makes the way in which social care is

purchased and provided very price-sensitive (Knapp et al. 2001; Forder et al. 2004). Although most care providers are in the private sector, pay levels are limited by public sector funding constraints.

Due to the sensitive nature of questions about pay, accurate measurement of wage levels is never straightforward. As will become clear below, different sources of wage data on care workers provide rather different figures. This may be due to differences in definitions (e.g. a broader or narrower definition of 'care worker' in terms of tasks performed), types of data (i.e. whether collected from workers or employers) and/or sample structures (i.e. whether or not all sectors of the workforce are included).

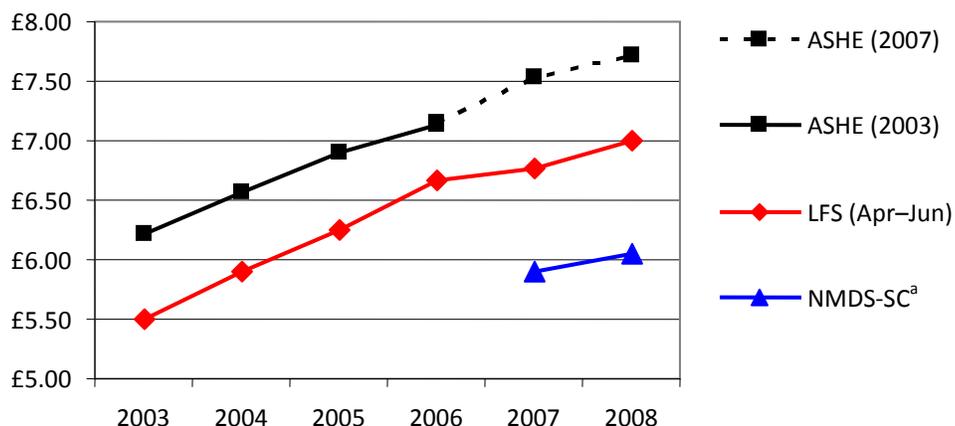
The most authoritative and reliable data source on the social care workforce in England is the Skills for Care National Minimum Data Set for Social Care (NMDS-SC), which is based on information provided each month by several thousand workers. According to recent estimates published by Skills for Care (2009a), the median gross hourly pay for care workers in all adult services was £6.56 (quarterly average for December 2008–February 2009): that is, a little above the National Minimum Wage level set in October 2008 (£5.73 for people aged 22 and over). This excludes senior care workers, whose estimated median gross hourly wage rate for the same period was £7.00. Lower pay rates are paid to care workers in the private sector (£6.30) than in the public and voluntary sectors. Differentials among different types of service providers are also significant: for example, the hourly pay of care workers is higher in domiciliary care (£6.80) than in nursing homes (£6.10).

Average rates of pay can also conceal regional variations as, unlike in the NHS, the cost of labour in social care settings is affected by local labour market conditions (Kendall et al. 2002). In December 2008–February 2009, the median hourly pay of care workers in England ranged from £6.80 in London down to £6.00 in the North East, North West and West Midlands. There are also wide differences in the amounts allocated by local authorities as direct payments (Davey et al. 2007), which has implications for the pay levels of workers caring for recipients of direct payments.

Figure 2.1 compares NMDS-SC estimates with the major national surveys typically used for the measurement of wage levels – the Annual Survey of Hours and Earnings (ASHE) and the Labour Force Survey (LFS). These two sources provide substantially higher figures for the median pay levels of the category 'care assistants and home carers' (SOC 6115). For April 2008, the difference between the highest estimate provided by the ASHE and the lowest based on the NMDS-SC (average of all care workers in adult services) was over £1.60 an hour (27 per cent).²¹

²¹ A full understanding of the factors underlying these significant discrepancies is beyond the scope of this report. Possible explanations may be found in the much smaller sizes of the ASHE and LFS samples of care workers (a few

FIGURE 2.1: GROSS MEDIAN HOURLY PAY OF CARE WORKERS ACCORDING TO DIFFERENT DATA SOURCES, 2003–2008



^a 2008 data collected or revised in April 2008. 2007 data collected in or before July 2007. Data include both care workers and senior care workers.

Source: Annual Survey of Hours and Earnings; Labour Force Survey; National Minimum Data Set for Social Care.

Despite the differences in absolute levels of pay, the three sources all show a consistent trend over time, namely a significant increase in care workers' pay rates, irrespective of the estimates used, between 2003 and 2008.²² Recently published NMDS-SC monthly statistics confirmed this trend, showing that median hourly rates of care workers in December 2008–February 2009 were 7 per cent higher than one year earlier (Skills for Care 2009a).

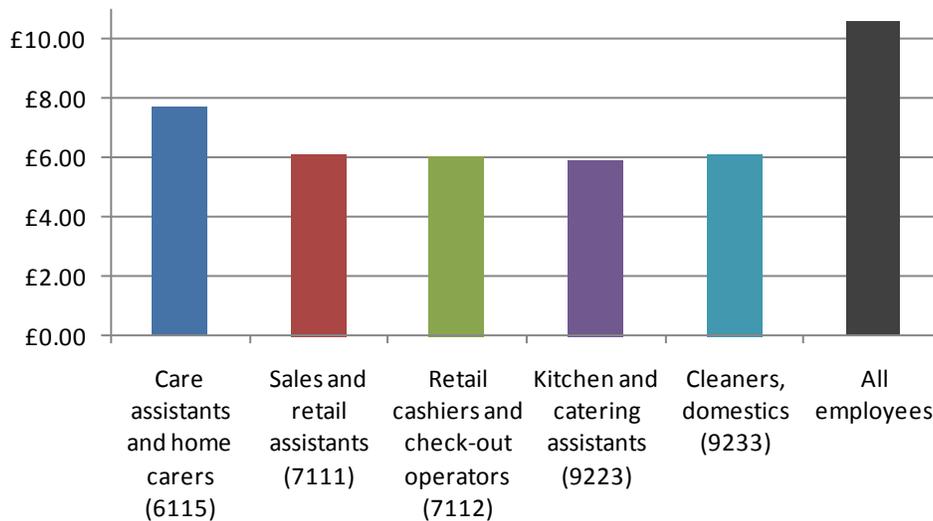
It is also interesting to note that this increase in care workers' average pay has contributed to widening the wage gap between care workers and workers in other low-skilled occupations. Between 2003 and 2008 care workers' wages' (based on ASHE figures) grew by 22 per cent, compared to 18 per cent for all employees (18 per cent). In 2008, care workers earned on

hundred, compared with several thousand for the NMDS-SC); the exclusion of NHS workers and the under-coverage of the local authority workforce – where higher wages are paid – by the NMDS; an under-representation of workers at the bottom of the pay distribution by the ASHE and LFS; and a possible bias of data based on employers' pay records in a sector where informal working arrangements are not uncommon – e.g. 'under-the-counter' and unreported payment of salaries below the National Minimum Wage. In contrast, the differences in geographical coverage do not seem to be very significant: although ASHE and LFS estimates refer to the UK and the NMDS-SC covers only England, the difference in median hourly wages in the care sector between England and the UK measured by the LFS is very small (£0.03).

²² Although pay levels have risen across the pay distribution, workers earning the lowest salaries experienced the largest improvement in their pay (e.g. wages have increased by 30% among the 10% of the workforce at the bottom of the pay spectrum). This seems to confirm that the introduction of the National Minimum Wage had a positive effect on the pay levels of the most disadvantaged workers.

average between 20 per cent and 30 per cent more than cleaners, kitchen assistants and workers performing routine tasks in shops and supermarkets but still well below the median for all employees (see figure 2.2).

FIGURE 2.2: GROSS MEDIAN HOURLY PAY OF CARE WORKERS, COMPARISON WITH OTHER LOW-PAID OCCUPATIONS, 2008



Source: Annual Survey of Hours and Earnings.

Although the median is a useful and commonly used indicator to ‘summarize’ the pay structure, it does not provide comprehensive information on the overall distribution of care workers across the wage spectrum – reported in table 2.2. According to the ASHE, there is greater variation of wage levels among care workers than for other low-paid occupations, e.g. in retail, cleaning and catering. This is likely to be related to the significant wage differentials between the private sector, local authorities and third sector organizations.

Comparison of the wage distribution based on different sources confirms and even emphasizes the variability of wage data for the social care workforce. For example, according to the ASHE the 10 per cent of care workers at the top of the wage spectrum earn at least £11.68 an hour, while according to the NMDS-SC the wage threshold identifying the ‘richest’ 10 per cent of the care workforce is £7.29 – about 40 per cent lower. Again, a possible explanation for this is that the ASHE may include in its sample a higher proportion of care workers employed in the public sector.

One specific question central to policy making is whether – and to what extent – sections of the workforce are paid below statutory pay levels. At the time to which the data in table 2.3 refer (April 2008), the National Minimum Wage (adult rate) was £5.52 an hour – it was increased to £5.73 from October 2008. Using the ASHE data, the Low Pay Commission estimated that, in 2008, 80,000 social care jobs (5 per cent) were paid *at* the minimum wage (7.8 per cent in the private sector), and 2.5 per cent of jobs were paid *below* the National Minimum Wage (Low Pay Commission 2009).²³ NMDS-SC data seem to be broadly consistent with these estimates, showing 10 per cent of care workers paid *at or below* the NMW (see table 2.3): a slightly higher figure which may reflect the under-representation of the public sector and the inclusion of some workers aged 18-21 possibly paid at the development rate (£4.60 in 2007/8). However, according to LFS estimates, this proportion is significantly higher: one in ten workers reported hourly pay levels below £4.95, and one in five below £5.56. A further breakdown shows that in only a minority of cases are these workers aged 21 or under, being paid at the development rate. Although it is possible that pay estimates based on self-reported information are downward-biased and that LFS figures may therefore overestimate the proportion of those paid below the National Minimum Wage, it is also likely that information on pay levels below the statutory requirements provided by employers (ASHE and NMDS-SC) is not fully reliable.

This variation of pay estimates presents a challenge to those attempting to establish wage thresholds with the aim of identifying the proportion of care workers to be regarded as ‘skilled’ – the approach adopted by the Migration Advisory Committee (MAC) in setting the criteria under which employers can apply for senior care worker visas (see section 3.2 below). For example, the wage threshold adopted by the MAC in its first report (November 2008) to identify the proportion of care workers hitherto regarded as ‘skilled’ was the 70th percentile of the pay distribution of the SOC category 6115 ‘Care assistants and home carers’, corresponding to £8.80 an hour on the basis of 2007 ASHE data. The wage paid at the 70th percentile varies hugely depending on the source used for the calculation: for 2008 it would be £9.11 on the basis of the ASHE and £6.50 using the NMDS-SC (table 2.3). Following the pressures from sector stakeholders claiming that £8.80 per hour was implausibly high, in the March 2009 revision of the shortage occupation list MAC has shifted to the LFS as a source for wage data – reducing the wage requirement for Senior Care Workers visas to £7.80 per hour. We return to this key issue in the next chapter when we deal with the points-based labour migration entry system.

²³ A study of personal assistants employed by recipients of direct payment found similar results: 8% of the workforce paid at or below the NMW (IFF Research 2008).

TABLE 2.3: PERCENTILES OF CARE WORKERS' DISTRIBUTION ACROSS THE WAGE SPECTRUM: COMPARISON OF DIFFERENT WAGE DATA SOURCES, APRIL 2008

	N	Percentile								
		10	20	30	40	median	60	70	80	90
ASHE ^a	686	£5.85	£6.29	£6.69	£7.19	£7.71	£8.32	£9.11	£10.11	£11.68
LFS ^{a,b}	366	£4.95	£5.56	£6.05	£6.54	£7.00	£7.67	£8.33	£9.19	£10.75
NMDS-SC										
<i>Care workers</i>	4,634	£5.52	£5.67	£5.80	£5.86	£6.00	£6.20	£6.39	£6.70	£7.18
<i>Senior care workers</i>	678	£5.67	£6.00	£6.10	£6.34	£6.68	£6.69	£7.00	£7.24	£7.99
<i>all care workers</i>	5,312	£5.52	£5.70	£5.82	£5.95	£6.05	£6.23	£6.50	£6.80	£7.24

^a Care assistants and home carers (SOC 6115).

^b LFS quarter April–June 2008.

Source: Annual Survey of Hours and Earnings, Labour Force Survey, National Minimum Data Set for Social Care (data extraction upon request by Skills for Care).

2.3.4 Vacancy and turnover rates

The vacancy rate in social care is nearly double that for all types of industrial, commercial and public employment (Eborall and Griffiths 2008), and the CSCI described filling jobs in this sector as an area of 'chronic difficulties' (CSCI 2006b: 1). Many of the vacancies in social care are termed 'hard to fill', generally because of skills gaps (that is, a shortage of suitably qualified candidates), rather than an overall shortage of applicants (Moriarty 2008). Recent trends show a sharp rise in the number of vacancies in the social care sector notified to Jobcentres in 2007 and 2008, mainly due to an increase in vacancies reported for care workers (CSCI 2009). This tendency appears to have been reversed since the beginning of 2009, arguably because of the consequences of the current economic downturn – see section 8.3 below.

Estimates based on NMDS-SC data published by CSCI (2009: 110–11) show that in 2007–2008 vacancy rates for care workers in England were pretty consistent across the care sectors – ranging from 4.4 per cent in the statutory sector to 4.8 per cent in the voluntary sector. However, the breakdown by type of service suggests a higher vacancy rate in domiciliary care (5.7 per cent) than in nursing homes (3.1 per cent). Turnover rates varied much more across sectors (9.6 per cent in the statutory sector, 15.8 per cent in the voluntary sector and 23.6 per cent in the private sector) but less by type of service. Vacancy rates in the statutory sector are lower in Scotland and are historically lowest of all in Northern Ireland (Moriarty 2008).

The NMDS-SC records reasons for leaving employment.²⁴ These data suggest that most social care workers leave the job for personal reasons. Among those who take another job, many

²⁴ However, it must be emphasized that the NMDS-SC collects data from employers, so the quality of the information on leavers is variable and affected by many missing responses.

move to another social care employer or the NHS. Only a small minority are thought to switch to the retail sector, in sharp contrast to anecdotal reports before the introduction of the NMDS-SC which had suggested that this was a frequent occurrence (Moriarty 2008).

2.4 The future of social care

The future structure and funding of social care are currently under consideration by government, as are measures to improve the quality of care through regulation and training provision (DH 2008). A key factor in the impetus for reform is the growing number of older people who will be in need of long-term care.

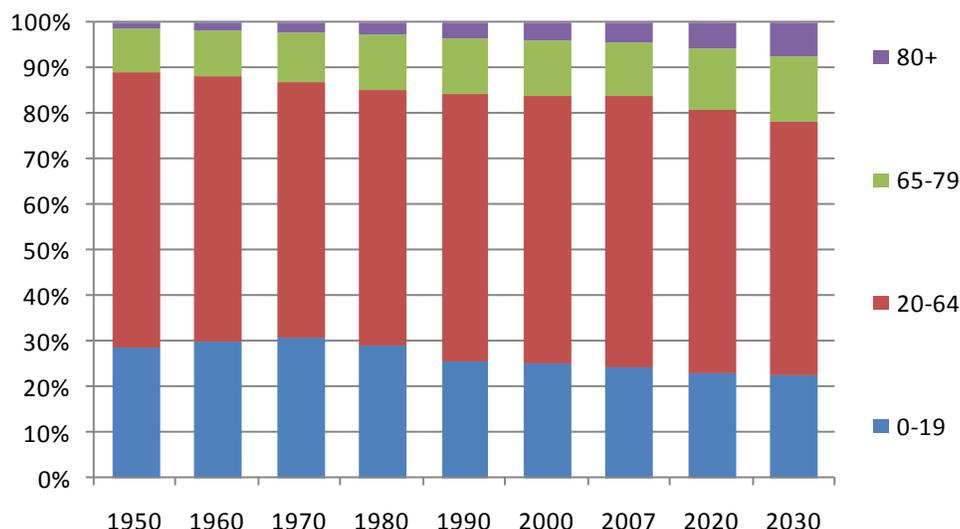
2.4.1 Ageing population

The ageing of the population in the UK in the second half of the twentieth century, as in other mature economies, was historically unprecedented and is expected to continue for the foreseeable future. As can be seen from figure 2.3, the UK population aged considerably over the past decades as the proportion of the population aged 65 years and over increased from around 11 per cent in 1950 to around 16 per cent in 2007. This ageing is projected to continue, with the proportion aged 65 years and over in 2030 increasing to 22 per cent, and the dependency ratio (the ratio of those aged 20–64 years to those aged 65 years and over) is expected to fall from 3.5 in 2007 to just 2.5 in 2030. There is also clear evidence of ‘double ageing’ – the proportion aged 80 years and over is expected to increase even more significantly, from just 1.5 per cent of the population in 1950 to 7.5 per cent in 2030. In terms of numbers the ‘older old’ population is projected to almost double between today and 2030 – from 2.75 million to 5.30 million.

One of the consequences of the growing number of older people is a rise in the number of cases of dementia. The National Audit Office estimates that this will rise from 560,000 in 2007 to more than 750,000 by 2020 and 1.4 million by 2051. Two-thirds of care home residents are estimated to have some form of dementia. Advances in medical knowledge and practice mean that disabled people can live longer and healthier lives, but the corollary of this is a need for care and support over a greater number of years. In 2001 the average man had nine years living with a long-term limiting illness compared with six years in 1981 (DH 2008 citing census data).²⁵

²⁵ The census definition of a limiting long-term illness is somewhat general and includes any long-term illness, health problem or disability that limits daily activities or work.

FIGURE 2.3: POPULATION TRENDS IN THE UNITED KINGDOM, BY AGE GROUP, 1950–2030



Source: United Nations (2006); GAD (2007); ONS (2008).

Skills for Care, using the NMDS-SC to model future workforce scenarios, estimates that, if all those adults (*all* adults; not only older people) in need of care received it, the adult social care workforce might need to rise by 1.1 million by 2025 (to a total of 2.5 million). This corresponds to its ‘maximizing choice’ scenario, which implies that the personalized services objective is fully met, including a greater proportion of personal assistants and a ninefold increase in those providing self-directed care via direct payments or individual budgets (Eborall and Griffiths 2008). Even the lowest projection – the ‘reining in’ scenario, implying reduced access to services – results in a significant increase of the care workforce (up to 2.1 million in 2025).

Although projections are always based on a set of assumptions and there is some degree of uncertainty about the future trends of demand and future workforce developments, all scenarios are consistent in showing that the social care workforce will need to expand considerably to meet the care needs of an ageing population. To shed light on the possible role of migrant workers in the future supply of care labour, in chapter 8 we develop our own scenarios on the developments of the care workforce and proportion of migrants within it.

2.4.2 Future of informal provision

We do not know how far informal care will expand to meet future demand for care of older people, particularly of the ‘older old’ in need of more intensive care (Howse 2008). Much attention has been given to the decline in co-residence between older people and their children

(Glaser 1997). A recent study modelling older people's future demand for informal care from their adult children found that demand is projected to exceed supply by 2017, with the 'care gap' widening in the following decades and reaching almost 250,000 care providers by 2041 (Pickard 2008). However, it has been suggested that proportionally more older people will be living with spouses and that as a result the consequences of a decline in any support from adult children may be less severe than is sometimes anticipated (Pickard et al. 2000).

People in the UK continue to have a high level of personal commitment in principle to providing support to family members, and most see the family as the primary source of such support, followed closely by government. The HSBC Global Ageing Survey (GLAS) found that 46 per cent of those aged 40–79 years in the UK think that the family should be primarily responsible for practical help in the home for older persons in need, compared to 40 per cent placing responsibility primarily on government. The survey found that 79 per cent of people aged 40–49 and 64 per cent of those in the 70–79 age group feel that it is the duty of adults to provide for their parents (and parents-in-law) in times of need later in life, and found that the reality of support is quite substantial. During the previous six months, 24 per cent of the 70–79-year-olds and 49 per cent of the 50–59-year-olds had provided practical support in the home to a relative or friend. 5 per cent of 70–79-year-olds and 17 per cent of 40–49-year-olds had provided personal care such as bathing or dressing (Leeson & Harper 2007a). Practical support around the home is provided primarily to 'other family' (not spouse/partner, children or grandchildren), with up to 64 per cent of all four cohorts (40–79) providing this support at least once a week (and 15 per cent on a daily basis). Personal support is also provided mainly to 'other family', with up to 70 per cent of the same cohorts providing this form of support at least once a week (with 25 per cent doing so daily).

While the support of family members thus remains important, their ability to respond to the needs of older relatives has been affected particularly strongly by the increasing labour force participation rates of women (Mestheneos & Triantafillou 2005). The effect of this combination of demands has been exacerbated by increasing longevity, so that middle-aged women in particular can find themselves with caring responsibilities for both (grand)children and parents (hence the coinage the *sandwich-generation* of women) while struggling to retain their position in the workplace.

Where older people can exercise choice, they may increasingly opt for formal services to provide certain types of care while looking to their families and friends to provide other types (Cameron and Moss 2007). However, although there is long-standing evidence that older people in the UK use formal services to enhance support from family members (Qureshi and Walker 1989; Wenger 1997), there is less evidence on relative preferences for paid and unpaid support. In particular, the personal nature of much care work with older people (Twigg 2000)

may mean that recipients' preferences for formal or informal care vary according to the type of care that is being provided.

2.4.3 New technology

With both the formal and informal sectors under pressure, the care sector has sought new ways of providing for older people's needs. Community care was introduced to reduce the institutionalization of older people and increase their independence, but this demanded mechanisms including new technology to enable older people to exercise that independence.

In the 1970s, care of older people in their own homes came within the realm of communication technology with the introduction of personal response systems, which enabled an older person to call for help in case of an emergency. The subsequent growth in the use of such systems was driven by changing demographics and family roles. This technology does not erase the need for personal support from family, neighbours, volunteers or professionals, but acts as an additional reassurance in circumstances where precisely these sources of support are not available round the clock.

Future developments in the technology of caring are likely to be driven by the same factors that saw its emergence – to enable the increasing numbers of older people to remain in the homes of their choice and live independent lives. 'Smart homes' will include information and communication technologies: speech recognition and generation devices, video and audio output, automatic communication capabilities, and the potential to control much of a frail older person's daily living by means of miniaturized sensors, transmitters and receivers ('bluetooth' technology). Personal response systems will be developed to monitor and control in-home healthcare equipment and to reduce (the sense of) isolation and provide social reassurance. It is less clear to what if any extent they will reduce the need for informal and paid care services.

2.5 Improving the quality of care

Government policy places strong emphasis on improving the quality of social care for older people (DH 2005b, 2008). There has been recent evidence of some serious deficiencies in the quality of care (Joint Committee on Human Rights 2007) but also of progress in protection, including the recent extension of the Human Rights Act 1998 to cover most independent care home residents and the intention to extend legislative protection from discrimination to older people in receipt of services in the Equality Bill 2009. Increasing demand for care provision and public funding constraints set a challenging context for achieving improvements in practice. Care provision is labour intensive, and therefore improvements in the quality of care will

depend in part on the staffing of the sector. In recent years, the focus of attention has been on regulation, training and user choice as means of improving the quality of services.

2.5.1 Regulation of services and of the workforce

Regulation of social care services and of the workforce has been one of the major ways in which the government has sought to raise standards of care for older people (Moriarty 2007).

The Care Quality Commission is responsible for regulating adult social care services in England and for registering and inspecting care homes and home care agencies. The Care Standards Act (2000) provides the basis for the regulation of social care in England and Wales (equivalent legislation is in force in Scotland and Northern Ireland). Care homes and home care agencies are expected to meet the relevant regulations for care homes (2001) and for domiciliary care agencies (2002), supplemented by a set of national minimum standards (NMS) relevant to the services they provide (DH 2003a, b). Unlike the regulations, the NMS are not legally enforceable but provide guidelines by which the quality of a service can be judged.

The White Paper *Modernising Social Services* (Secretary of State for Health 1998) highlighted the fact that 80 per cent of social care staff had no recognized qualifications or training at that time and that few regulations governed the way in which they practised (section 5.3). Since then, the social care workforce has been accorded priority in the government's plans for modernizing social care, and changes have taken place to the policy and regulatory framework in which it operates.

The NMS include standards on staffing that social care providers are expected to meet. They cover social care workers employed by local authorities and by private and third sector organizations, but – significantly – not personal assistants employed by older people using direct payments or on individual budgets, or carers employed by older people or relatives privately funding their care. The standards for entry into formal social care jobs stipulate checking for any criminal record, following up references and verifying qualifications, although concerns have been expressed that these procedures are not always followed correctly by employers (CSCI 2006a). There are also standards on staff training and supervision, including provision of induction training for new staff within six weeks of appointment to their post and foundation training within six months (as well as an individual training development assessment). The NMS set a target that at least 50 per cent of care workers at each workplace should hold a National Vocational Qualification (NVQ) at Level 2 (in the National Qualifications Framework) in health and social care by 2005 (2008 for home care providers). The Care Quality Commission is currently consulting on the replacement of the NMS with a new standards framework from 2010.

2.5.2 Training and registration

The conduct and training of the social care workforce is regulated by the UK Care Councils, including the General Social Care Council (GSCC) in England, which was established under the Care Standards Act 2000 and opened its register in 2003. All four UK Care Councils have set up Social Care Registers of people working in social care who have been assessed as trained and fit to be in the workforce after checks on their qualifications, health and 'good character'. Registered social care workers are also required to complete post-registration training and learning activities before renewing their registration every three years. Currently, only qualified social workers and social work students are required to be on the registers, but other occupations, including care assistants, are in the process of being added.

The GSCC is currently preparing a system for regulating home care workers, and is expected to open a register for them in 2010, setting minimum standards for registration. Registration will, however, initially be voluntary, with the expectation that it will be made compulsory at some later stage. It will not include personal assistants, pending consultation, and in relation to staff in care homes the Department of Health has said only that options for the registration of additional groups of social care workers 'will be kept under review' (DH 2009: 7). Registered workers are required to adhere to a Code of Practice for Social Care Workers, described by the GSCC as 'a critical part of regulating the social care workforce', which sets out standards of professional conduct that workers should meet. Employers are also expected to adhere to a Code of Practice for Social Care Employers which sets out their responsibilities in the regulation of social care workers. The Care Quality Commission takes the Code of Practice for Social Care Employers into account when enforcing care standards.

Historically, social care workers' access to training has been limited. Training has been identified as an important way of improving recruitment and retention and of ensuring that workers have the skills to meet the future demands of their role (DH/DES 2006). It has nevertheless been argued that the provision of training may not be enough on its own to improve the quality of care (Balloch et al. 2004; Wanless 2006), not least given the funding and staffing constraints of the care system.

Considerable investment has taken place in funding training for social care workers, albeit from a very low base (Learning and Skills Council 2006), with a view to increasing the number of care workers qualified to NVQ Level 2. Evidence on training and qualification levels in the workforce is still fragmented.²⁶ Available information suggests that the objectives set by the NMS for care

²⁶ NMDS-SC data are still incomplete because a number of employers have not reported the qualifications of their workers.

workers (see above) have not yet been achieved, although considerable progress has been made. CSCI data show that the proportion of providers achieving (or exceeding) the NMS target for NVQ qualifications has been rapidly increasing over recent years (CSCI 2008b). However, by the end of March 2007 between 10 and 30 per cent of CSCI registered providers had not met the qualifications standard: the lowest achievements were reported for private home care agencies and the highest for local authority residential homes.

LFS data also suggest an improving picture, showing that there has been an increase in the qualifications of care workers. In 2007 just over 66 per cent of care workers said they had obtained the equivalent of an NVQ Level 2 or higher, in comparison with fewer than 60 per cent in 2006 (CSCI 2009). However, this information is not subject-specific, and so may include people acquiring NVQ qualifications in areas not relevant to social care. Nevertheless, registrations and certificates awarded for care-related NVQs have been increasing (Eborall and Griffiths 2008). One interesting point to emerge from our analysis of the migrant care workforce is that new arrivals are over-represented among care workers enrolled in training (but not necessarily training related to care work, see section 4.9 below).

Concerns have been expressed that smaller providers and workers without basic literacy skills find it particularly difficult to access suitable training and support (Balloch et al. 2004; Cameron and Moss 2007). There are, moreover, few financial incentives for workers to acquire qualifications as the pay differential between people employed as senior care workers and the basic grade is often very small (Balloch et al. 2004; McLimont and Grove 2004). Although only a minority of the workforce hold a professional qualification, it is estimated that 66 per cent of direct care workers are working towards a relevant vocational qualification (Skills for Care 2007a). Of these, the majority are aiming to acquire an NVQ (in 2010 the NVQ system will be replaced with a Qualification and Curriculum Framework, or QCF).

In April 2009 the budget made provision (up to £75 million) to subsidize 50,000 new traineeships in social care, to be provided by employers offering work and training to young people who have been out of work for 12 months to enable them to acquire the skills to start a career in social care. An Adult Social Care Workforce Strategy published by the Department of Health in the same month said the personalization agenda needed 'a more confident, competent, empowered and diverse workforce with increasingly sophisticated skills' but made no mention of any role that migrant workers might play in the future workforce, suggesting that a diverse staff should be drawn from within local communities (DH 2009: para. 70).

A National Skills Academy for Social Care, established in March 2009, has a responsibility to provide training support to small and medium-sized care providers in particular, in recognition of their limited training budgets. Among its roles are the provision of training programmes for

employers and an accreditation scheme to encourage consistency in quality in training provided to care workers.

The policy objective of improving the quality of care through the 'professionalization' of the social care workforce raises the issue of care-related skills which may not be addressed through a qualifications-based approach alone. The social construction of care work and of social care workers as 'low-skilled' points to the gender bias inherent in the undervaluing of women's unpaid care work (Lewis 2006) and in their low-paid status in the formal provision of care. Whether training policies will lead to improvements in the quality of care for older people depends among other factors on how care work is valued and on recognition of the skills that shape the quality of care for older people. The quality of care is generated in the relationship between care giver and care user – a point emphasized in the social care literature and reflected in recent policy documents that give greater recognition to the significance of people, including staff and service users, in determining the quality of experiences of care (Newman et al. 2008).

A key question regarding the role of migrant workers in the provision of care for older people, as we shall see in chapter 6, concerns not simply the formal qualifications of workers, but recognition of the importance of the care relationship between worker and user, and the conditions under which those relationships can be developed and supported. A key concern facing all care workers is the time pressure of delivering care in understaffed and time-constrained circumstances, which has been found to impact on the quality of care practice. A report by the CSCI identified widespread problems in home care provision in relation to the shortness, timing and reliability of visits, with older people often reporting care workers to be 'rushed' (CSCI 2008). This raises the question of the extent to which 'relational care' can be delivered under such conditions.

2.5.3 Regulation of care provided at home

The shift towards home care including the direct employment of carers by older people, while extending choice, raises issues of regulation to protect both older people and their carers. *Putting people first* recognized a potential tension between extending choice and ensuring protection for care users, stating that 'the right to self determination will be at the heart of a reformed system only constrained by the realities of finite resources and levels of protection, which should be responsible but not risk averse' (DH 2007b: 2).

Early findings suggest that the currently small but growing number of direct payment users, including older people, are more satisfied with the service they receive from personal assistants than they had been with the care provided by their local authorities. Recipients reported

greater reliability and flexibility from their carers and lower levels of psychological, financial and physical abuse. Personal assistants also reported high levels of satisfaction, with only one in five concerned about long hours and one in three about low pay. Only 34 per cent had, however, been given a job description; employers gave low priority to previous experience or job training, and only a minority supported compulsory registration (Skills for Care 2008a). A recent report by CSCI found local authorities beginning to develop systems to help prevent abuse of people who direct their own support 'but the evidence indicates that no council yet has a systematic approach in place. Information and support to people funding their own care was also variable between councils' (CSCI 2008a).

2.6 Conclusion

In this chapter we have reviewed policy and practice in the provision of social care and support for older people, in institutions and in their own homes. Informal care by families and friends remains the dominant form of provision. Formal care, while largely publicly funded, is provided primarily by the private and voluntary sectors. The future provision and funding of formal services, in which there has been a shift from institutional care to care in the community, are the subject of current policy debate. Personalization and user choice, through direct payments and individual budgets, have been and will continue to be a central theme of reform, coupled with improvements in quality through regulation of services and improvements in training of the workforce.

The adult social care workforce in England totals 1.5 million jobs, some 5 per cent of the total workforce. Of those a large majority (905,000) provide direct care. Most of the care workforce is employed by the private and third sectors, and a small but growing number work directly for individuals receiving direct payments. It is a predominantly female workforce, ageing and low-paid, albeit better paid than some other occupations deemed 'low-skill'. Skills for Care estimates that the adult social care workforce as a whole will need to grow to at least 2.1 million, potentially 2.5 million, by 2025. Across the UK, the number of care workers (individuals) working with older people can be estimated at 642,000 in 2006/7.

Currently 1.1 million older people use social care services out of an estimated 2.5 million older people with care needs, with evidence of unmet demand. Population ageing will significantly increase the future demand for care, particularly because of the rising number of 'older old', those over 80, who are projected to double by 2030. The future availability of family and friends to provide informal care, and (at the margins, perhaps) the scope for technological developments to reduce demand, are further factors in the equation.

This situation raises a number of issues relevant to the current and future employment of migrant workers in the sector. First among them is the extent to which migrants may be needed to meet some of the expanding demand for care – a question notably absent from most current policy debates on the future of the care system.²⁷ Another is whether their employment would reproduce or extend the workforce inequalities already present in this sector of the labour market. The switch to direct payments and individual budgets in some cases transfers the responsibility for recruitment and employment to the older person (or their family), blurring the roles of care user and employer and raising difficult questions for the regulation of the quality of care provided, the training and suitability of the carer recruited, and protection of their employment rights, when the care is provided not in an institution but in a person's own home. These are issues to which we return in the chapters which follow, first on migration policy – which is curtailing channels of entry for some care workers at the very time when demand could rise – and then reporting on the findings from our own research with employers, migrant workers and older people.

²⁷ Although the introduction of the new points-based immigration system in the UK has now drawn attention to the determinants of labour shortages in relation to the need for migrant labour in the UK economy (Anderson and Ruhs 2008; MAC 2008), and in the care sector specifically (Moriarty 2008).

3. Migration Policy and Practice in the Social Care Sector

UK migration policy is in a state of flux. The labour migration entry system in particular is being replaced with a points based system controlling entry to work in the UK. This system overhaul, including reforms affecting those who come to the UK to study and for working holidays, is significantly changing the entry criteria and conditions of stay of the majority of migrant workers who, along with workers from the European Union, have found employment in the health and social care sectors.

3.1 Historical reliance on migrant workers

The UK has historically relied heavily on overseas doctors and nurses in staffing the National Health Service (NHS) and, to a lesser extent, in social care. Active recruitment of health professionals from the Indian subcontinent and Caribbean was facilitated in the post war period by relaxed entry controls for Commonwealth citizens, so that by 1967 almost half the junior doctors employed in the NHS had been born outside the UK and Ireland (Rose et al. 1969). The subsequent work permit system continued to facilitate access to shortage occupations including doctors, nurses and related health professions. From the late 1980s to the late 1990s (1984–8 to 1995–9), foreign employment in the health and medical sector rose by 47 per cent, an increase over three times that in the number of foreign born workers overall during that period, which stood at 15 per cent (Dobson et al. 2001: 195).

By the late 1990s the government was being advised to work towards self-reliance in UK-trained doctors and nurses, and investment in training was substantially increased. In 1997/8 some 5,000 trainee doctors entered UK medical schools; by 2005/6 the number had risen to nearly 8,000. The NHS Plan 2000, based on an increase in funding of the NHS by one-third over five years, anticipated the numbers of nurses and doctors growing by 10,000 and 20,000 respectively over that period. Although it foresaw self-sufficiency in doctors and nurses in the long term, it acknowledged that this immediate expansion would still require significant overseas recruitment (DH 2000: paras 5.4, 5.22). The Department of Health actively supported health trusts recruiting abroad both within and beyond the EU, and the Home Office allowed health professionals to enter on its fast track work permits for shortage occupations and doctors through its Highly Skilled Migrants Programme. Work permit data show permits for the health and medical services industry overall, including associate professionals such as nurses and senior care workers, rising from 1,774 in 1995 to a peak of 26,568 in 2004, some 30 per

cent of all permits issued (Salt 2007: table 5.2). Nurses were also able to work via a Working Holiday Maker scheme.

Following enlargement of the EU on 1 May 2004, the government allowed East Europeans from the 'Accession 8' (A8) countries to work in the UK.²⁸ While the numbers taking up posts as health professionals have remained low, this new source of labour proved more significant for low-skilled jobs in the social care sector, where a total of 23,580 had registered employment by March 2009. The number newly registering to work in the care sector peaked in 2005 at 6,880, falling to 4,340 by 2007. In contrast, the further enlargement of the EU to include Bulgaria and Romania in January 2007 led to highly restricted access to the UK labour market.

As late as 2005 a White Paper, *Controlling our borders, making migration work for Britain*, foresaw continued reliance on non-EEA doctors and nurses in an expanding NHS, anticipating their entry through Tiers 1 and 2 of the new points system then in its early planning stage. In a foreword to the White Paper, the Prime Minister, Tony Blair, stated: 'Our vital public services depend upon skilled staff from overseas. Far from being a burden on these services, our expanding NHS, for example, would have difficulty meeting the needs of patients without foreign born nurses and doctors.'

In the event, a series of developments in the NHS and in the medical and nursing professions led to a significant fall in recruitment. One result of this was that by the time the new points based entry system was rolled out in 2008, recruiting from abroad (beyond the EEA) was no longer allowed for most health professional posts. Most significant among these developments was a financial crisis in the NHS, leading to a freeze in recruitment to many posts in 2005/06, and a surplus of UK-trained medical graduates for postgraduate training positions, leading to a clampdown from 2007 on doctors from abroad taking up these posts. In nursing, reform by the Nursing and Midwifery Council in 2005 of the Overseas Nurses Programme (ONP) for non-EEA-trained nurses, involving a 20-day adaptation programme and placements approved by educational institutions, for which only 1,500 places a year were available, caused a backlog of 37,000 in nurses seeking registration (Bach 2007). Bach suggests that these registration requirements may in practice serve as an additional means to manage migration flows as the delay may discourage applications. Prior to the reform many of these nurses had completed their placements in private nursing homes (Buchan et al. 2005), effectively an entry channel for migrant workers into the social care workforce.

Work permit data after 2004 show a sharp decline in the number of permits for entry to work in health and medical services. The major source countries for associate professionals such as

²⁸ Of the ten countries admitted to the EU in 2004, migrants from eight of the 'accession' states were subject to certain restrictions. (The exceptions were Malta and Cyprus.)

nurses and senior care workers in 2006 were India and the Philippines, followed by South Africa and Australia (Salt 2007: tables 5.3 and 5.4).

3.2 The new points based entry system

The points system introduced in 2008 replaced more than 80 entry channels for non-EEA migrants wishing to work and study in the UK with five categories for entry known as Tiers 1 to 5. The stated rationale was to provide an efficient and transparent system that would be more effective in identifying and attracting those migrants with the greatest contribution to make to the UK. In practice the tiers are not dissimilar to the entry channels they replace, both systems resting on a distinction between 'skilled' and 'low-skilled' jobs, largely measured by the prospective earnings, qualifications, training and experience required. An expectation that any labour shortages in low-skilled jobs would largely be met by East Europeans from the enlarged EU encouraged the government to conclude that entry channels for low-skilled workers from outside the EEA were unlikely to be needed.

For the highly skilled, Tier 1 allows entry to work in any sector of employment, without a job offer. This route replaces the Highly Skilled Migrants Programme. Tier 2 replaces the work permit system and (currently) covers skilled jobs where the employer has been unable to recruit, and a fast track for shortage occupations, on which the Government takes advice from a panel of experts, the Migration Advisory Committee (MAC)²⁹. The shortage list will not, as had initially been expected, include most doctor and nurse positions. Tier 3, currently suspended, is intended for temporary low-skilled jobs. It has been the Home Office's intention not to set a precedent by opening up a temporary workers scheme for low skilled jobs in any sector, and it has shown no sign of wanting to depart from this for social care. Tier 4 is for students and Tier 5 covers youth mobility and certain categories of temporary workers.

Tier 2, in operation from November 2008, allows licensed employers to sponsor workers from outside the EEA to fill vacancies where advertising has failed to provide suitable applicants, or without advertising if the post is included on the list of shortage occupations. To secure enough points to qualify them for this tier, a migrant must have a certain level of English language skills, sufficient funds to support themselves for the first month and – significantly, for those not on

²⁹ Occupations to be included in the list are assessed against three criteria: whether they qualify as 'skilled', whether they have a demonstrable shortage of applicants from the UK labour market, and whether it is 'sensible' to fill vacancies within these occupations with non European Economic Area (EEA) workers. Since its establishment, the MAC has committed itself to regularly re-assess the jobs on the shortage occupation list, carrying out partial reviews every 6 months and a full review every 2 years (MAC 2008a, 2009b).

the shortage list – prospective annual earnings of more than £24,000, a level which excludes most jobs in the social care sector.

Tier 2 is significant for jobs in the care sector. Under the previous system, senior care workers were eligible for work permits: a stipulation that posts require qualifications at National Qualifications Framework (NQF) Level 3 was applied with some flexibility.³⁰ Between 2001 and 2006 over 22,000 new work permits were issued for senior care workers – around 5,000 a year between 2003 and 2006 (Home Office 2008). In 2007, the Home Office decided that such posts should no longer qualify as ‘skilled’ and thus eligible for a work permit unless they required formal qualifications at NVQ Level 3 and were paid at least £7.02 per hour. As a result of these restrictions of the eligibility criteria, only 1,005 new permits were issued in 2007, and 5 in the first ten months of 2008. Care sector employers argued that they could not afford to pay the higher hourly rate and trades unions protested that many of those currently employed would therefore be unable to renew their permits. As a result many senior care workers would have to leave the UK, caught simultaneously by a rule change in 2006 extending the qualification period for application for the right to remain in the UK from four to five years. The Home Office responded, following advice from the Department of Health, with transitional arrangements allowing permits for senior care posts to be renewed temporarily without compliance with the skills criteria if the salary was raised to the higher rate.

When the points system was introduced (September 2008) the Home Office was advised by the MAC that, with the exception of Scotland, senior care worker posts did not qualify as sufficiently ‘skilled’ to be eligible for Tier 2 entry and should be included on the shortage list only if paid £8.80 per hour. The committee argued that, although it was not realistic to expect wages to rise in the care sector in the short term given the reliance on public sector funding, over a longer period it would expect wages in public sector shortage occupations to rise. It argued that ‘in the longer run it would not be sensible to supply these important services on the basis of low-paid immigrant labour’ (MAC 2008a).

The criteria proposed by the MAC meant that a smaller proportion of senior care workers’ posts could be filled by migrants entering through this direct entry channel. Nor were overseas nurses allowed to apply for permits under Tier 2 to work in the care sector as most nurse positions were by now neither considered ‘shortage occupations’ nor attracted sufficient ‘points’ for employers to sponsor a migrant through this channel. Care home managers argued in response that this would make it ‘more difficult for care homes which struggle under the current funding system to find staff’ and that the elderly would bear the brunt of the decision. The Home Office nevertheless accepted the MAC advice in its published list of shortage occupations in November

³⁰ A qualification at NQF Level 3 in the care sector is Level 3 NVQ.

2008, but asked the MAC to give further consideration to the position of senior care workers by Spring 2009.

In response to the consultation launched by the MAC to inform its April 2009 revision of the shortage occupation list, a significant body of evidence was gathered and submitted by Skills for Care & Development (SfC&D) – an alliance of six organisations operating in the care sector – and by a number of other sector stakeholders. The key message was unanimous in stressing that the wage threshold set by the MAC was too high compared to the pay levels prevailing in the care labour market, particularly those paid by private care providers. Much emphasis was placed on the budget constraints under which many providers relying on public funding were operating and their impact on the staff costs they could afford (SfC&D, 2009). UNISON also expressed concern about the difficulty of renewing work permits for care workers already working in the UK and about the unintended consequences for workplace cohesion triggered by employers paying higher wages to workers with similar experience and performing the same tasks but recruited overseas rather than on the local labour market (UNISON, 2009).

COMPAS also submitted evidence based on the preliminary findings of this project, reporting on the experiences of employers responding to our survey and on the outcomes of our analysis of care workers' wages. The latter shed some light on the methodological reasons why the wage threshold set by the MAC was in practice very high – essentially, the great variability in the measurement of wages based on different statistical sources and the fact that MAC had used the source providing the highest estimates (ASHE).

In its April 2009 shortage occupation review, MAC changed the basis of its calculation of the pay threshold and its advice to government, suggesting that the wage requirement for entry for senior care workers be reduced to £7.80 per hour. It also acknowledged the funding constraints in the sector. It lowered the formal qualifications required from the previous NVQ Level Three down to NVQ Level Two (or equivalent), but suggested two additional criteria relevant to dimensions of skills measurement: that the post holders have at least two years' relevant experience and have supervisory responsibility in the work place. This advice was accepted by the Government.

In December 2008 the MAC had also reported to government on the labour market implications of relaxing restrictions on another potential source of workers, 'A2' nationals from Bulgaria and Romania (the 'Accession 2' countries that had entered the EU in 2007) (MAC 2008b). It noted that the Department of Health had argued that to do so could help the social care sector:

'for the unskilled staff in the social care setting, allowing A2 labour market access could ease labour shortages in the social care sector; shortages we expect to be exacerbated under the points-based migration system... Any reduction in the

*availability of low-skilled migration in the sector could reduce the number of available workers in this sector, with significant potential implications for Government expenditure. We would therefore welcome relaxation of A2 labour market restrictions as a route to addressing some of these concerns.'*³¹

However, some in the care sector argued that limited English language proficiency would be a barrier to employment in care work. The MAC concluded that while there might be scope for a scheme for A2 nationals to enter the sector it was also likely that, with freedom of movement in the labour market after 12 months, they would leave care work at that time to find better pay and conditions. Having broader reservations about increasing the supply of low-skilled migrants in the UK economy, the MAC did not recommend that the government adopt such a scheme.

Although the impact on source countries is beyond the scope of our study, it is interesting to note the effect which the tight restrictions on entry to the UK for care workers have had on the Philippines, which has recently seen a dramatic increase in training provision of care workers entirely for 'export'. The country has long been a major provider of qualified nurses but between 2002 and 2008 the number of recognized providers of training for care givers, a six-month vocational course, expanded from 150 to 918. However, the training is strongly orientated towards the Canadian market as the qualification, along with English language skills acquired in a school system in which English is one of the main languages of instruction, makes these care givers eligible to migrate to be care workers in Canada, but not in the UK (Gordolan 2008).

3.3 Students and other migrants employed in social care

International students (non-EEA) are generally allowed to work for up to 20 hours per week during term time and full-time during the holidays. Those studying nursing are allowed to work beyond 20 hours if the job is a necessary part of the course. Students from EEA countries can work without permission. A survey in 2004 of almost 5,000 international students (including EEA students) in universities and colleges by UKCISA, the UK Council for International Student Affairs (formerly UKCOSA), found that just over half had undertaken paid work since coming to the UK, of whom only 29 per cent were in employment related to their programme of study or future career. More than 70 per cent were paying their fees and living costs from their own or their family's resources (UKCOSA 2004). It is known that a proportion of international students

³¹ MAC (2008b: para. 7.112).

work in the care sector but there is no data which reveal the extent of reliance on this source of labour.

The future capacity of students to work in the care sector to fund their studies or as part of their nursing or care work training has been affected by the recent reforms of entry controls. To gain entry under Tier 4, students now have to show that, in addition to the course fee, they have savings of £800 per month for nine months of the year ahead (or £600 outside London), a move designed in part to reduce their reliance on working to support their education while in the UK. Universities UK, representing 132 universities, argued that this would deter those students who currently rely on paid work to enable them to study from coming to the UK.

Some care homes are employing social care 'students' who effectively work full time (35–40 hours per week), with limited classroom time, a means by which they and the agencies that recruit them can avoid the restrictions on entry to work in the sector. These care workers are registered for a course leading to social care qualifications, making them eligible to enter on student visas. As the course is 'work based learning', hours spent at work count as hours spent in study.

In addition, some of those working in the care system entered the UK through a Working Holiday Maker scheme under which young people from a range of countries could come to the UK for up to two years and work during that time. Labour force data do not reveal the immigration status of care staff, so that the extent of reliance in social care on working holiday makers is not known. This scheme has now been replaced by Tier 5 of the points-based system, which has more restrictive criteria: only Australia, Canada and New Zealand are currently (May 2009) part of the scheme; applicants have to be sponsored by their own government; and they must show that they have £1,600 to support themselves when they arrive. This is likely to reduce the future availability to the social care sector of migrants through this channel. The Recruitment and Employment Confederation has suggested, for instance, that the absence of South Africans from the scheme will affect the supply in particular of live-in carers, a role that is not seen as an attractive option by EU workers (REC 2008). Citizens of Commonwealth countries who have one grandparent born in the UK are still allowed to come and work in the UK without a work permit for up to five years (and may then apply for permanent residence) under what are known as the 'UK Ancestry' provisions, currently under review.

Migrants who enter to marry a UK or EEA citizen are eligible to work in the UK, and some find employment in the care sector. Access could become more limited if the Home Office were to pursue a proposal to introduce an English language test for those seeking entry for marriage and raise the age of entry for marriage to 21, but those measures might be expected to have limited impact on the numbers of spouses working in the care sector.

Although it is not possible to enter the UK to take up a post as a domestic worker, it is possible to do so as a live-in domestic worker accompanying a family who are coming to live in the UK. Some of these workers are thought to be providing care to older people in the home. The Government intended to incorporate this entry route into the Tier 5 temporary worker category and introduce a restriction on stay to six months, in place of the current more flexible arrangements that allow these workers to change employer and potentially remain in the long term. In July 2008, however, it announced that the current arrangement would remain in place for the next two years. Young people who have entered as au pairs may also be looking after older people.

3.4 Joined-up policy making

In its reform of labour migration policy the Home Office is advised by a series of advisory panels, including a panel on the healthcare sector on which the Department of Health and social care providers are represented. Nevertheless, the lack of reference in Home Office policy documents on these various reforms to the significant reliance of the social care sector on migrant labour suggests that the potential implications for the sector may not initially have been adequately considered. The pressures on the Home Office to limit entry channels and in particular to cut the numbers of those coming to the UK provide a formidable driver for policy change, and it was evident from our engagement with both the Home Office and the Department of Health that officials felt that internal communication in Whitehall prior to the reforms on entry had been limited and their implications for provision of social care not fully taken into account. Care providers represented on the Work Permits Healthcare Sector Panel issued a statement in August 2007 expressing their concern that ‘the Panel has been sidestepped in the review of policy in the issuing of work permits for senior carers’ and citing ‘overall poor communication with the care home sector’. The Royal College of Nursing, meanwhile, had criticized the government’s decision to remove most nurses from the national shortage occupation list, arguing that it had failed to take account of shortages outside the NHS including within the care home sector.

3.5 Enforcement

Enforcement of the immigration rules governing migrants’ eligibility to work in the UK was in the past applied with a relatively light touch: only 11 successful prosecutions of employers were brought in 2007 for employing migrants not eligible to work, although more have been targeted

since the introduction of a wider and more punitive range of penalties in February 2008. Those targeted appear to be concentrated in the catering sector.

The introduction of identity cards for foreigners in the UK is intended to facilitate enforcement. It is argued that they will make it more difficult for those whose status is irregular to obtain a job in this or any other sector of employment. Cards began to be introduced in November 2008 for international students and those entering on the basis of marriage, and it is anticipated that 90 per cent of foreign nationals will have an identity card by 2014.

Under the points based system, employers wanting to recruit migrant staff through Tier 2 must obtain a licence, a process in which they may be subject to inspection on a number of grounds (for instance, to establish that a care home is registered with the relevant care inspectorate) and face the loss of their licence if found to be employing anyone without permission to work.

3.6 Codes of practice on international recruitment

As recruitment of health professionals from developing countries rose during the 1990s, the UK was criticized for 'poaching' staff from countries experiencing skill shortages, affecting their ability to provide adequate healthcare services to their own populations. Guidelines first developed in 1999 for recruitment from South Africa and the Caribbean were developed into a Code of Practice for the Active Recruitment of Healthcare Professionals in 2001, limiting active recruitment by the NHS unless approved by the government of the country concerned. The code was strengthened in 2004 but remained voluntary for recruitment by healthcare providers in the private sector. Nor did the code prevent recruitment initiated by individual health professionals themselves. In 2002/3, a quarter of nurses registering to work in the UK were from developing countries where NHS active recruitment was proscribed (Buchan and Dovlo 2004: 15). The saliency of debate on the effectiveness of the code in reducing the exodus of health professionals from developing countries has declined following the tight curbs on recruitment now in place.

A Social Care Code of Practice for International Recruitment was developed by the Social Care Institute for Excellence (SCIE) in 2006; it has been endorsed by government and by a small number of local authorities and private care recruitment agencies and providers. Significantly, the code also has a strong focus on employers' responsibilities in relation to the employment rights of their migrant workers in the UK, and on ensuring the suitability of the workers for undertaking care work.

3.7 Integration of migrants

The UK has no reception or integration strategy for new migrants who are not asylum seekers or refugees. Back in 1965 when the first Race Relations Act was introduced, most members of Britain's ethnic minorities were first generation migrants to the UK, many arriving for work or family reunion in that decade. Over the years, however, the government's race equality policy, in continuing to focus on traditional ethnic minority communities with long term residence rights, has paid less attention to those migrants who have recently arrived. Nevertheless, there are some policies and services that are intended to contribute to their economic and social integration.

There is an explicit Home Office integration strategy for refugees, until recently based on *Integration matters*, dating from 2005. Together with the Department for Work and Pensions' (DWP) refugee employment strategy, it 'sets out the rights and responsibilities of refugee status and puts an emphasis on gaining the skills to give something back to the community'. The DWP had taken action in 2003, in *Working to rebuild lives*, to help refugees enter the labour market by means including assistance in obtaining national insurance numbers and bank accounts, providing interpreters to enable them to use Job Centre Plus, facilitating access to the New Deal, offering work-focused language tuition, and supporting professionals wishing to adapt their qualifications to practise in the UK.

Integration matters, a strategy for England complemented by separate strategies in Scotland and Wales, defined integration as 'the process that takes place when refugees are empowered to achieve their full potential as members of British society, to contribute to the community, and to become fully able to exercise the rights and responsibilities they share with other residents'. The strategy identified factors considered key to integration: employment, English language, volunteering, contact with community organizations, acquisition of citizenship, housing standards, incidence of racial, cultural or religious harassment, and access to education. A Refugee Integration and Employment Service (RIES) was established in 2008 offering a case-worker service for 12 months to provide advice, employment support and mentoring to every individual granted refugee status or humanitarian protection in the UK. In March 2009 the Home Office emphasized partnership with the voluntary sector in delivering this agenda, in *Moving on together: government's recommitment to supporting refugees*.

In contrast to the attention given to the integration of refugees (many of whom nevertheless face significant challenges), the Government has had no equivalent strategy to foster the integration of other newcomers to the UK. The limitations of that approach were highlighted by the experiences of East European migrants following enlargement of the EU in 2004. Research found that these migrants, even when in employment and able to afford some accommodation and despite being white Europeans, experienced many of the same difficulties as refugees in

respect of lack of English language proficiency, lack of information on rights and access to services, and in some cases lack of social contact with non-migrants (Spencer et al. 2007).

The government's prime concern in relation to newcomers has been their impact on local services. An Audit Commission report, *Crossing borders* (2007), identified a series of challenges including community tensions, overcrowding in private rented accommodation posing health and safety risks, and communication barriers faced by local services in meeting the needs of newcomers. Prior to publication of the Audit Commission's report, the government had established a Commission on Integration and Cohesion to consider the ways in which local areas can contribute to forging cohesive communities. The Commission's report (CIC 2007) was the first to bring issues relating to new migrants within the policy debate on community cohesion. It also addressed the need for an integration strategy for new migrants and recommended the establishment of a new agency to coordinate local initiatives, a recommendation the government rejected.

3.7.1 English language tuition

One area of service provision that is targeted at new migrants is English language tuition, on which government expenditure has more than tripled in recent years in response to a threefold increase in enrolments on courses between 2001 and 2005. Nevertheless, demand for places continues to exceed supply. The government has restricted free tuition to those receiving welfare benefits, while continuing to subsidize the fees of those on low incomes, arguing that 'We have to prioritise mainstream funding on the poorest who are committed to remain [in the UK] but for whom English language is a significant barrier to getting or keeping work.' It introduced new ESOL (English for speakers of other languages) for work short courses in 2007 and hoped that employers of migrant workers would in future contribute to the tuition costs. The shortage of courses and evidence that some courses are not appropriate in their content nor in their attendance requirements for migrants working anti-social hours, remains a challenge for migrants and for ESOL course providers. There are nevertheless innovative examples of work related ESOL provision, including for migrants employed in the care sector.

3.7.2 Citizenship

For those planning to remain in the UK in the long term, the government has recently used access to citizenship as a means to encourage applicants to acquire a level of knowledge about the UK, and to establish that they have an adequate proficiency in English. A formal test was introduced in 2005 and extended to applicants for permanent residence in 2007. In February 2008 the Home Office published a consultation paper, *The path to citizenship*, proposing that

applicants for citizenship should in future also have to demonstrate an economic and social contribution to the UK, and evidence of compliance with UK tax and other legal requirements. It argued that a new stage of 'probationary citizenship' should be established, lengthening the time it would take to acquire full citizenship, during which time access to benefits and services would be restricted. Among the ways in which prospective citizens could demonstrate a contribution to the UK would be by doing voluntary work with a recognized organization. The proposed changes are included within the current Borders, Citizenship and Immigration Bill (January 2009), under which an application for citizenship or permanent residence could be delayed for up to two years (from six to eight years for an economic migrant or refugee, for instance) if the applicant could not demonstrate 'active citizenship' through volunteering or community work. The Home Office is reportedly considering setting a minimum number of hours (50–100 hours over a set period) for this work.³² This proposal clearly has implications for migrant care workers who are working long and anti-social hours on low pay, sometimes with two jobs, and for whom it may therefore not be practicable to make an additional contribution of this kind.

3.8 Legal rights

The terms of entry to the UK for some migrants preclude full access to economic, social and political rights. Those who come to work, to be united with families or as students are generally not allowed to access public funds, in particular welfare benefits, and have to pay higher 'overseas' fees for vocational training and further education (a barrier for migrant care workers who want to pursue NVQ qualifications). They can, however, send their children to state schools and have access to some free healthcare through the NHS. Citizens of Commonwealth countries are allowed to vote in national as well as local elections, and those from EU countries to vote in local and European elections.

Migrants allowed to work in the UK have the same employment rights as other employees, subject to any restrictions linked to their immigration status, for instance on their right to change jobs. Many of the challenges that migrant workers experience at work have been found to be related to lack of awareness of their employment rights or unwillingness to challenge malpractice by employers. The government has established an advice hotline for all 'vulnerable workers' including advice on issues such as the National Minimum Wage and health and safety. Employment rights are tied to the worker's employment status: if their contract of employment

³² See Volunteering England: briefing on the Borders, Citizenship and Immigration Bill, March 2009, <http://www.volunteering.org.uk/NR/rdonlyres/4343DB40-B0E9-4287-8F5F-7D5FA39E1B2C/0/VolunteeringEnglandactivecitizenshippublicbriefingMarch09.pdf>

is not valid because they are not allowed to work, they are unlikely to be able to claim rights relating to that employment, such as, for instance, challenging any discrimination they may experience. Migrants, like other employees, have fewer rights if they are working in private households: most significantly, in relation to the National Minimum Wage and Working Time Regulations 1998³³.

3.8.1 Protection of migrant workers from discrimination including harassment³⁴

Our findings reveal that some older people and their families do not welcome care provided by migrants (chapter 7). This requires us to consider the respective rights and responsibilities of employers, older people and migrant care workers in these circumstances. We therefore set out here the relevant legal framework and return to it in our recommendations in the final chapter.

The UK has well-developed anti-discrimination legislation, first introduced for racial discrimination in 1965 (and strengthened subsequently, most recently in 2000 and 2003); this is supplemented by provisions outlawing discrimination in employment on grounds of gender, disability, sexual orientation, age, and religion and belief. These provisions, while somewhat technical, are highly significant for our study as they impose responsibilities not only on care providers and recruitment agencies but also on older people and their families. We focus here on the provisions most relevant to the migrant workers in our study – those outlawing discrimination on grounds of race, religion and belief.

The law covers *direct* discrimination (less favourable treatment) and *indirect* discrimination, where a requirement is applied equally to all job applicants or employees but fewer people from a particular racial or religious minority can comply with it. Indirect discrimination is unlawful unless the requirement can, despite this effect, nevertheless be justified. Discrimination on ‘racial grounds’ means less favourable treatment on grounds of *race, ethnic or national origins*, and in some cases on grounds of *nationality or colour*. It is because of the way in which European law on discrimination has been brought into UK law that the provisions relating to discrimination on grounds of nationality and colour can differ from those on race, ethnic and national origins. They do so in one respect relevant here, namely discrimination that takes place in relation to jobs in private households. We return to this issue below.

³³ See the position statement of the UK Home Care Association in this respect (July 2007):

<http://www.ukhca.co.uk/pdfs/PSmanagingworkingtimeinliveincare.pdf>.

³⁴ This section draws with gratitude on a legal Opinion provided by Catherine Casserley, a barrister specializing in employment and discrimination law at Cloisters, Temple, London EC4.

Discrimination law, which specifically covers employment agencies as well as employers, prohibits discrimination in recruitment, when the individual is in employment, and in relation to post-employment situations (such as references). It is also unlawful to instruct or induce someone to discriminate on grounds of race, ethnic or national origins, religion or belief.³⁵ A care home (or older person employing a carer directly) thus cannot (in most circumstances) tell a recruitment agency to find (or avoid) someone of a particular race. Nor can relatives tell the manager of a home, for instance, that they do not want the home to employ staff of a particular racial background, or that they must not allow those staff to look after their relative.

Harassment on racial grounds is also unlawful. This is defined as ‘unwanted conduct which has the purpose or effect of violating the other person’s dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment’ for the person concerned.³⁶ The courts have found verbal racial abuse to constitute harassment.

3.8.2 Employer’s liability in relation to discrimination

An employer is liable for discrimination, including harassment, by their employees, whether or not they know about it unless they have taken all reasonably practicable steps to prevent the behaviour; and damages can be awarded against both the employer and the employee responsible. If the discrimination or harassment is perpetrated by a third party, however, such as a resident in a care home, it is more difficult to establish that the employer is responsible – but recent case law suggests that this will be less difficult in future. If the care worker suffered foreseeable damage from the harassment (such as psychological injury), the employer’s liability could also be challenged under separate legislation, the Protection from Harassment Act 1997.

An employer may consider that they need to remove an employee from a situation in which a service user is verbally abusive in order to protect the employee from harassment, but in so doing find that they have discriminated against the worker by putting him or her in a less favourable work situation than their colleagues. An employer would be expected by an employment tribunal to have a robust policy in place to protect employees from harassment; and, if a public authority, to have included action in this regard within the steps taken to fulfil its statutory duty to promote racial equality (see below). An employer could, for instance, advise a resident in a home that they will have to leave if the harassment of the care worker continued. However, a public authority could if it failed to make alternative provision, be challenged under the Human Rights Act for failing to provide the care service – a situation of

³⁵ S3A Race Relations Act 1976, enforceable only by the Equality and Human Rights Commission. The inducement does not need to be made directly if made in such a way that the person is likely to hear of it.

³⁶ If the harassment is on grounds of colour or nationality, however, it has to be challenged as direct discrimination rather than as harassment and is likely to be more difficult to prove.

competing rights which public bodies and other employers are likely to want to take steps to avoid.

An individual who believes that they have been the victim of employment discrimination must usually lodge a complaint with an employment tribunal within three months and can be awarded compensation. Case law suggests that a migrant who is in the UK unlawfully or is working without permission, however, is not protected by discrimination law as their contract of employment is itself unlawful. Nevertheless, case law on this issue predates the most recent law reforms, and in future cases a tribunal might not give such clear priority to immigration law over freedom from discrimination in employment.

3.8.3 Private households

Significantly for our purposes here, private households were initially exempt from the race legislation – that is, it was not unlawful to refuse to employ someone in a private household on grounds of their race. Since the law was amended in 2003, however, it has been unlawful for an individual employing someone in their own home to discriminate on grounds of race, ethnic or national origin (but still lawful to do so on grounds of nationality or colour). It is also unlawful to discriminate on grounds of religion or belief (for instance, to refuse to have a Muslim or atheist carer).

An elderly person who directly employs a carer in their own home thus bears all of the responsibilities of an employer in relation to discrimination and harassment that have been described above. This is significant given the trend towards direct employment of carers by older people, and our findings in chapter 7. It is currently the case that if they were to refuse to employ someone on the basis of nationality – for instance, ‘a Zimbabwean’ – or on the basis of their colour (‘because she is black’), they could argue that this choice remains lawful in private homes. However, particularly if the rejection were accompanied by remarks suggesting that the real reason for the decision was in fact the applicant’s ethnicity, it would be open to legal challenge. In a very recent case the Employment Appeal Tribunal emphasized the link between colour and race, saying that the different grounds of discrimination overlap ‘and in many, perhaps most, cases they will be practically indistinguishable’. Further, it argued that ‘it is very hard to conceive of a case of discrimination on the ground of colour which cannot also be properly characterised as discrimination on the ground of race and/or ethnic origin’.³⁷ The Equality Bill introduced in April 2009 would remove this distinction entirely.

³⁷ *Abbey National v. Chagger* [2009] IRLR 86.

3.8.4 Exemptions in discrimination law relevant to social care

The law does allow employers to claim, in relation to a particular job, that it is ‘a genuine and determining requirement’, and proportional, that they employ someone of a particular race, ethnic, national origin, religion or belief. This is known as a Genuine Occupational Requirement (GOR).

The proportionality test is important. It might not be proportional for an employer to argue that they need a care worker of a specific race because they need the worker to cook in a particular style, for instance, if that skill could be easily learned; but it could be proportional to argue that they need someone who speaks a particular language as it takes a long time to improve language skills. There is no case law clarifying the extent to which an employer could in practice rely on the GOR provision in relation to race; nor any official guidance on whether, for instance, an older person’s refusal to be cared for by someone of a particular race could ever be sufficient grounds for the employer to claim that it is necessary to rely on the GOR exemption in this case. If the care user had mental health difficulties the employer might find it easier to make that case.

The Commission for Racial Equality Statutory Code of Practice on Racial Equality in Employment suggests that the GOR provision can be used if it is a reasonable means to achieve a legitimate aim – for instance, to employ a health worker of Somali origin for a job promoting access by Somalis to local health services because of the knowledge of culture and language involved in carrying out the work (CRE 2005: 91). In relation to religion the government’s guidance is that the GOR can be used only if religion is ‘essential’ to the post and the requirement cannot be met in another way, for instance by getting another member of staff to fulfil that function.³⁸

There is an earlier provision, now applying only to nationality or colour, in which those characteristics can be a Genuine Occupational Qualification (GOQ) for a job, for instance on the stage or in a restaurant (where necessary for authenticity). Significantly for our purposes, this provision can also be used where ‘the holder of the job provides persons of that racial group with personal services promoting their welfare and those services can most effectively be provided by a person of that racial group’.

Case law has clarified the nature of ‘personal services’ in a way that would include the direct care provided in social care for older people. It has also clarified that the provision should be used only where the language, culture or religious background of the carer is of ‘material importance’ – but this is nevertheless a much broader exemption than the more recent GOR,

³⁸ Department of Trade and Industry, ‘Explanation of the Provisions of the Employment Equality (Religion or Belief) Regulations 2003’, para. 73.

which in effect can be used only if there is no alternative.³⁹ The GOQ provision cannot be used where the employer already has sufficient employees of the racial group in question who are able to do the job, without undue inconvenience.

If the employer has sympathies with a particular religion or belief – for instance, a care home run by a faith-based charity – employment can be restricted to individuals with that religion or belief using the lesser test of ‘a genuine occupational requirement for the job’. In this case the worker’s religion does not need to be a decisive factor for the employer to argue that it is a requirement of the job (e.g. if the care staff fulfil the spiritual needs of care users as well as their physical needs).⁴⁰ The Advisory, Conciliation and Arbitration Service (ACAS) guidance on this provision says that this exemption cannot be claimed if the nature of the role and the context in which it is carried out are not of sufficient profile or impact within the organization to affect the overall ethos of the organization.⁴¹

Significantly, there is no procedure for determining in advance whether a post does fulfil the requirements to claim one of these exemptions. An employer needs to be confident that their case would stand up to challenge in a tribunal, and this may help to explain why the provisions appear to be little used.

3.8.5 Implications of discrimination law for older people

With the very limited exceptions set out above, the law thus imposes responsibilities on older people, as care users and as employers, not to harass anyone or treat anyone less favourably on racial or religious grounds (or indeed on grounds of gender, disability, sexual orientation or age). While the Sex Discrimination Act (s. 7) makes limited provision for gender to be taken into account in jobs involving physical contact in order to protect decency or privacy, there is very limited scope in the care relationship to claim that a particular race or religion may be specified. Thus, if an older person simply does not want to be looked after by someone of a particular race or religion, they may not act on that preference when employing a carer or by asking a care home or agency to do so. If there is a genuine reason why they need a carer of a particular race or religion, they may claim exemption under the GOR or GOQ provisions, but could be challenged to defend their reasons in an employment tribunal. If their concern is on other grounds, for instance that the carer’s English is difficult to understand, their concern would need to be articulated clearly in those terms.

³⁹ *Tottenham Green Under Fives Centre v. Marshall* ([1998] IRLR 147); *Lambeth LBC v. CRE* [1990] IRLR 231.

⁴⁰ Employment Equality (Religion or Belief) Regulations 2003, SI no. 1660 (regulation 7).

⁴¹ ACAS, ‘A guide for employers and employees: religion or belief and the workplace’, http://www.acas.org.uk/media/pdf/f/l/religion_1.pdf.

Older people also have rights as service users: service providers have a responsibility not to discriminate against them on grounds not only of race, religion and belief but also of gender, disability and sexual orientation. Only discrimination on grounds of age in service provision is currently not covered by discrimination law, but the Equality Bill published in April 2009 makes provision for this to be prohibited. Under the Human Rights Act 1998 individuals have a qualified right to privacy, but it is unlikely that the courts would allow that right to trump the care worker's right to freedom from discrimination.

3.8.6 Duty on public bodies

It is important to note that the law in Britain has been extended beyond anti-discrimination provisions to place a duty on public authorities when fulfilling their functions to have 'due regard to the need to promote equality of opportunity and good relations between persons of different racial groups'. Larger organizations such as local authorities must publish a scheme setting out how they intend to do this. Significantly, public bodies are also expected to reflect this duty in their contracts with any service providers that they fund, including care providers. Where local authorities provide older people with an allowance to employ a carer, it is arguable that they should similarly consider how, in so doing, they ensure that they fulfil their duty to promote race equality – for instance by inserting non-discrimination provisions into the condition of payment.

While this duty to promote equality does not directly cover jobs and services in the private sector, the obligation not to discriminate does apply across the public, private and voluntary sectors. The impact of the law will be extended by the Equality Bill 2009, which includes an explicit reference to the relevance of the duty in the procurement function.

We shall return to these issues when we explore the employment situation and care relationships of migrant workers and older people in chapter 7, and in our final chapter on the way forward.

3.9 Conclusion

Migration policy has been and remains in a period of transition. The UK historically relied heavily on overseas doctors and nurses staffing the NHS. It continues to do so in the social care sector but, with the limited exception of senior care workers, most migrant care staff have entered through non-labour-migration entry channels – for family union or protection as a refugee, to study, or on working holiday or ancestral visas. Most recently, recruitment has been enhanced by migrants from within the enlarged EU, although their numbers are now in decline.

Rule changes have limited employers' access to senior care workers through the labour migration points based system, and new rules for international students and working holiday makers are likely to reduce the numbers available to work in care jobs. Earlier rule changes had restricted migrants' access to permanent residence. In these respects we argued that there appeared to be some lack of joined-up policy making between the Home Office and the Department of Health in considering the implications of migration reforms for labour shortages within the care sector.

Penalties for the employment of migrants not eligible to work have been substantially increased and, after limited enforcement activity over many years, the number of prosecutions is now rising. The introduction of identity cards for migrants is intended to make it more difficult for them to access work for which they are not eligible.

The UK has no reception or integration strategy for migrants other than refugees. There are services relevant to integration, such as English language tuition, although there is evidence that it can be difficult for those working anti-social hours and on low pay to gain access to and pay for classes. The UK does have a well-developed system of anti-discrimination and equality legislation to provide protection for employees and service users from discrimination and harassment. Conversely, the law gives employers – including older people and their families who are employing carers directly – responsibility to avoid discrimination, and some responsibility to ensure that staff are not discriminated against or harassed by a service user. Employers may in exceptional circumstances claim that it is a genuine occupational requirement or qualification that they employ a carer of a particular race or religion, but this exemption is rarely used.

4. The Migrant Social Care Workforce

In this chapter quantitative evidence on the employment of migrant workers in social care is presented and analysed. Drawing on a pooled sample of the Labour Force Survey (LFS) and on our survey of organizations providing care to the older population, we estimate the size and review the trends and major characteristics of the migrant workforce in social care.

We focus on two occupations, care workers and nurses. Where possible and useful, we compare the characteristics and outcomes of the migrant and UK born workforce. In our analysis we use the country of birth as a proxy to identify the migrant workforce. A further distinction is made between ‘recent migrants’ (people who came to the UK in the last ten years) and ‘non-recent migrants’ (people who have been in the country for more than ten years).

At the beginning of the chapter, we provide estimates of the migrant workforce in care-related occupations. We reconstruct the major trends of care workers’ and nurses’ migration over recent decades, and estimate the numerical contribution of migrants to the recent development of the workforce in both health and social care. We review the main migration routes and their evolution over recent decades, looking at the countries of birth of the migrant workforce; and we give an estimated breakdown of the migrant care workforce by immigration status. We then compare the migrant and UK born components of the workforce in respect of demographic profile, geographical distribution across the UK and employment sector.

In the final part of the chapter we narrow down the scope of the analysis by considering only care workers employed by private businesses, voluntary organizations and local authorities – the main providers of care services to the older population. We review the main employment patterns of migrant workers in these jobs, their wage distribution and their turnover rates.

4.1 Data

Two main data sources are used in this chapter: the LFS and our own survey of organizations providing care for older adults. Further evidence from administrative sources, for example the Nursing and Midwifery Council’s (NMC) register and the Worker Registration Scheme (WRS), and estimates from previous studies are also reviewed. For different reasons, other major statistical sources are not useful in looking at the migrant workforce: the NMDS-SC does not include information on nationality or country of birth (see section 2.3 above), while the 2001 census does not capture the great changes that have taken place since the beginning of the decade.

As we shall see, the estimates provided by the LFS and our survey in respect of care workers are on the whole consistent. However, one important difference which has to be borne in mind while reading this chapter is that while our survey covers only the workforce employed by providers of residential and domiciliary care for older clients, LFS estimates refer to *all* nurses and direct care workers – including those working in different settings (e.g. NHS hospitals) and/or with other types of clients (e.g. adults with physical and mental disabilities). Therefore, comparisons between the two sources must be made with caution, because the survey results refer to a subset of the workforce included in the occupational categories for nurses and care assistants used by the LFS. While for care workers the overlap between the two sources is large (about 70 per cent of care workers working in adult care look after older people) this is not the case for nurses, about three-quarters of whom work for the NHS and only a small proportion of whom work in long-term care for older people. A more in-depth account of the samples and methodologies of data collection is given in appendices 1 and 2.

4.2 Estimates of the migrant workforce in social care

According to the most recent LFS estimates, 135,000 foreign born care workers were working in the UK in the last quarter of 2008 (table 4.1). For a number of reasons – discussed in appendix 1 – this has to be regarded as a conservative estimate. Migrants accounted for 18 per cent of *all* care workers, i.e. a higher proportion than the share of foreign born workers in the overall labour force (13 per cent). The weight of migrants in the care workforce has more than doubled over the past decade: in 1998 only 8 per cent of care workers were foreign born.

Migrant workers make up an even larger proportion of the nursing workforce – 23 per cent, up from 13 per cent in 1998. However, most nurses are employed in healthcare, so this proportion does not reflect the contribution of migrants to the nursing workforce in social care. The stock of nurses working in long-term care with older people can be estimated at about 60,000 (2006/7, see appendix 5). As we will see below, migrant nurses are disproportionately concentrated in this group.

Table 4.1 also presents the breakdown of the workforce by UK or foreign birth in other care-related occupations. It shows that the employment of migrants is widespread across the social care sector, not only in the less skilled occupations (19 per cent of childminders and 17 per cent of nursing auxiliaries are foreign born) but also among professionals (14 per cent of social workers are foreign born).

TABLE 4.1: ESTIMATES OF THE WORKFORCE IN SELECTED CARE-RELATED OCCUPATIONS^a IN THE UK, BY UK / FOREIGN BORN, OCTOBER–DECEMBER 2008

	Absolute values (000)			% of foreign born
	Foreign born	UK born	Total	
Care workers (6115)	135	595	730	18%
Nurses (3211)	122	417	538	23%
Nursing auxiliaries (6111) ^b	40	191	232	17%
Housing and welfare officers (3232) ^c	16	160	176	9%
Childminders and related occ. (6122)	23	95	118	19%
Youth and community workers (3231) ^d	8	111	118	6%
Social workers (2442)	14	87	100	14%
<i>All workers</i>	<i>3,807</i>	<i>25,539</i>	<i>29,346</i>	<i>13%</i>

^a The four-digit codes of the Standard Occupation Qualification 2000 are given in parentheses.

^b Occupation description includes personal care tasks.

^c Occupation description includes some elements of social work, and organization of domiciliary care services.

^d Occupation description includes some elements of social work.

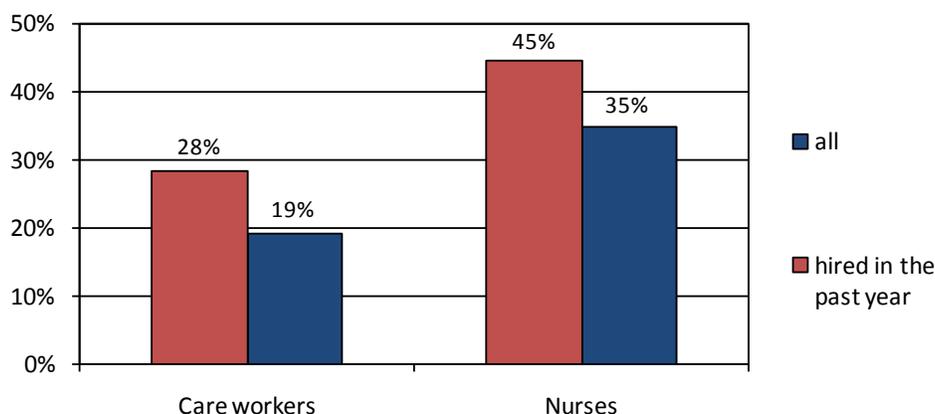
Source: Authors' elaboration on the Labour Force Survey. Notes on occupation description are drawn from table in Eborall and Griffiths (2008: 49).

For care workers, estimates of the migrant workforce from the COMPAS survey are broadly consistent with the LFS (table 4.1). The slightly higher proportion of migrant workers found in our sample (19 per cent) may be attributable to a higher concentration of migrants in the private sector and in the provision of care for older people (see section 4.8 below).⁴² The increasing reliance on migrant workers to fill in vacancies in the care workforce is confirmed by the significantly higher proportion of migrants among care workers who were hired in the year preceding the survey (28 per cent).

According to our survey, migrant nurses account for over one-third (35 per cent) of the nursing workforce in older adult care (table 4.1), which is considerably higher than the share of foreign born workers in the overall nursing workforce estimated by the LFS (23 per cent). The above-mentioned over-representation of migrant nurses in nursing homes in the independent sector (private + voluntary) has been documented by previous surveys (Ball and Pike 2007a); for more details, see section 4.8 below.

⁴² As outlined in appendix 2, the private sector is over-represented in our survey. The analysis presented in section 4.8 shows that demand for migrant workers is higher in private businesses than in organizations managed by local authorities and in the voluntary sector.

FIGURE 4.1: PROPORTION OF MIGRANTS AMONG CARE WORKERS AND NURSES IN OLDER ADULT CARE. ALL WORKERS AND WORKERS HIRED IN THE YEAR PRECEDING THE SURVEY, 2008



Sample: 557 residential and home care organisations employing 13,846 care workers and 1,867 nurses.

Source: COMPAS survey of employers (2008).

The proportion of migrants among nurses hired in the year preceding the survey is even higher (45 per cent), again suggesting that employers are increasingly turning to migrants to fill vacancies in the nursing workforce, despite the restrictions on international recruitment introduced in 2006.

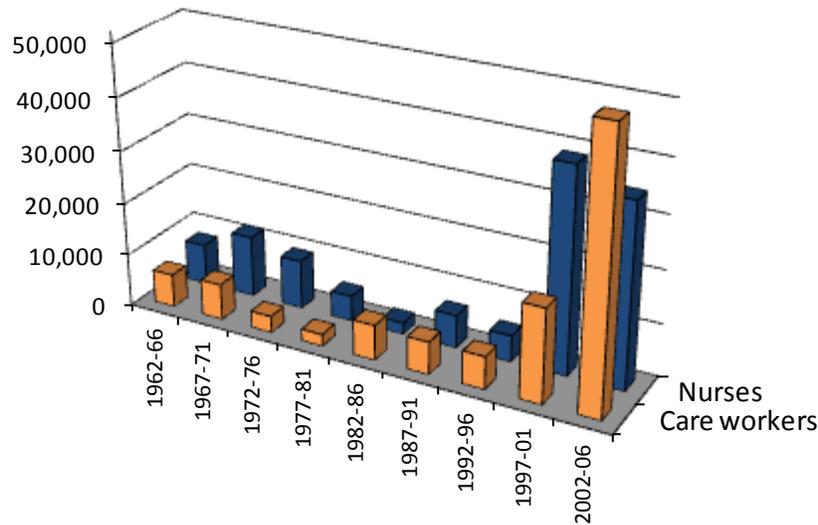
4.3 Trends and flows

In the absence of a comprehensive breakdown by occupation of migrant workers arriving in the UK, a general idea of the inflows of foreign born workers taking up jobs as nurses or care workers over recent decades can be drawn from the LFS stock data using the retrospective information on the year of entry. However, the breakdown by year of entry of the current stock of migrants working as care workers or nurses is a very crude measure of past inflows, considerably underestimating the actual number of arrivals in the corresponding years.⁴³

⁴³ The breakdown by year of entry of the foreign born workforce *now* working in care and nursing does not include people who have left the country or have shifted to other occupations. Also to be taken into account is the structural under-coverage of the migrant population by the LFS. Arguably the underestimation is more pronounced for less recent inflows, a larger proportion of whom can be assumed to have left the country. However, the current stock may also include people who have joined the care and nursing workforce years after their migration to the UK.

Figure 4.2 clearly shows that the arrivals of migrants who are currently working in these occupations have increased at unprecedented levels since the mid-1990s. In fact almost half of the current stock of migrant care workers and nurses entered the UK since the beginning of the current decade. Interestingly, while arrivals of migrant nurses far outnumbered those of care workers at the end of the 1990s and beginning of 2000s, the opposite is true in the most recent years.

FIGURE 4.2: STOCK OF FOREIGN BORN CARE WORKERS AND NURSES BY PERIOD OF ARRIVAL, 2007/8



Source: Authors' elaboration on the Labour Force Survey.

For nurses, better estimates of arrivals are provided by the admissions of overseas-trained nurses to the register of the NMC.⁴⁴ For example, in the five-year period 2001–5, 67,237 overseas-trained nurses registered with the NMC, a significantly higher number (+40 per cent) than the 48,000 foreign born workers who entered the UK in the same period and are currently working as nurses according to our LFS-based estimates.

The most recent statistics on the NMC registrations of migrant nurses testify to the significant decline in overseas recruitment which followed the marked increase in domestic training, the introduction of 'Return to Practice' schemes, and the restrictions introduced in the work permit

⁴⁴ The NMC's statistics on admissions of overseas-trained nurses are also likely to underestimate the inflow of foreign born nurses because they do not include foreign born nurses who registered after completing their training within UK-based institutions.

system (Hutt and Buchan 2005). In 2007/8 only 4,181 nurses trained outside the UK (2,309 in non EEA countries) were admitted to the NMC register, in contrast with 15,155 in 2003/4.

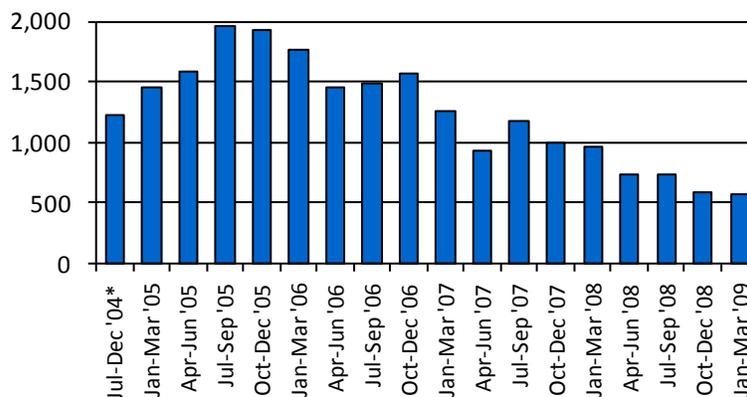
As far as migrant care workers are concerned, comprehensive administrative statistics on the new arrivals are not available. For A8 nationals, some indication of the gap between the actual number of arrivals and the current stock of care workers – which captures only those who are still in the country *and* still work in the care sector – can be drawn from a comparison between the LFS estimates and the cumulative number of migrant care workers who have registered with the WRS since the EU enlargement of 2004. This comparison suggests that the cumulative inflows of A8 care workers exceeded by something between 68 per cent and 117 per cent the current stock measured by the LFS.⁴⁵ The corresponding ratio for migrants from other countries of origin is probably lower, owing to a higher geographical and labour mobility of East Europeans.⁴⁶ Assuming that actual inflows were 40 per cent greater than the current stock measured by the LFS – the same ratio as for nurses – we obtain a very rough estimate of about 120,000 migrant workers who have entered the UK since the beginning of the 2000s and work (or worked) as carers.

The most recent WRS figures show that migration from the new EU member states has dramatically decreased over the past three years (figure 4.3). Registrations of care assistants between January and March 2009 (565) are just above half of the corresponding figure for the same quarter of 2008 (965), and just above a quarter of the peak figure reached in July–September 2005 with 1,965 registrations. Although there are no exact figures on the number of A8 workers leaving the country, estimates also suggest an acceleration of the pace of return to rates of about 40–50 per cent within a few years from emigration (Pollard et al. 2008; Lemos and Portes 2008; Iglicka 2008).

⁴⁵ This estimate is only indicative and based on the comparison between the cumulative number of WRS registrations for the period from July 2004 to December 2007 and the breakdown by year of entry of the stock of A8 care workers estimated by the most recent LFS surveys (third and fourth quarter of 2008). This is because the LFS includes in its sample only migrants who have been residing in the UK for at least 6 months, so Q3 and Q4 of 2008 include people who have entered the UK until the end of 2007. The range is obtained by dividing the cumulative WRS registrations by (1) the whole stock of A8 nationals employed as care workers and (2) the stock of A8 nationals who entered the UK from 2004 onwards. The two denominators correspond to the two opposite situations in which (1) all A8 nationals who entered the UK before 2004 and were still in the country at the time of the EU enlargement registered with the WRS and (2) only those who entered the UK after the 2004 enlargement registered with the WRS.

⁴⁶ This can be assumed because of the relatively high return rate of A8 migrants – roughly estimated at 40–50 per cent (Pollard et al. 2008; Lemos and Portes 2008) – and the freedom of EU nationals to take up any job from the beginning of their stay in the UK – which results in higher turnover rates than among non-EU nationals whose immigration status can restrict their access to the labour market.

FIGURE 4.3: A8 NATIONAL CARE ASSISTANTS REGISTERED WITH THE WORKER REGISTRATION SCHEME, JULY 2004–MARCH 2009



* quarter average.

Source: UKBA, Accession Monitoring Reports.

Further evidence on the evolution of the foreign born workforce over the last decade and its contribution to the overall workforce employed as care workers and nurses can be obtained by comparing the most recent LFS estimates with those provided by previous LFS waves. Figure 4.4 displays the variation in the size of the UK born and foreign born workforce in two five-year periods (1998–2003 and 2003–8).

As far as care workers are concerned (figure 4.4a), both groups contributed to the significant expansion of the workforce observed over the two periods. Both the growth of the overall workforce and the contribution of migrant care workers to this expansion are particularly remarkable between 2003 and 2008: nearly half of the additional 155,000 workers who joined the social care workforce were foreign born. In relative terms, the migrant workforce has more than doubled over this period (+112 per cent).

In contrast, towards the end of the 1990s the nursing workforce experienced a contraction, decreasing by about 20,000 workers (figure 4.4b).⁴⁷ This was the result of opposite trends for the UK born (–35,000) and the migrant workforce (+15,000, a relative increase of 23 per cent over the five years). As a consequence of the significant recruitment of overseas-trained nurses and the considerable investment in the training of new local workers, the figures for the following five-year period show an increase of the nursing workforce by nearly 60,000 workers, most of whom were migrants (with a remarkable growth rate of 54 per cent).

⁴⁷ This is consistent with the data from the NMC register.

FIGURE 4.4: ABSOLUTE AND PERCENTAGE VARIATION OF THE CARE AND NURSING WORKFORCE, BY UK / FOREIGN BORN, 1998–2003 AND 2003–2008



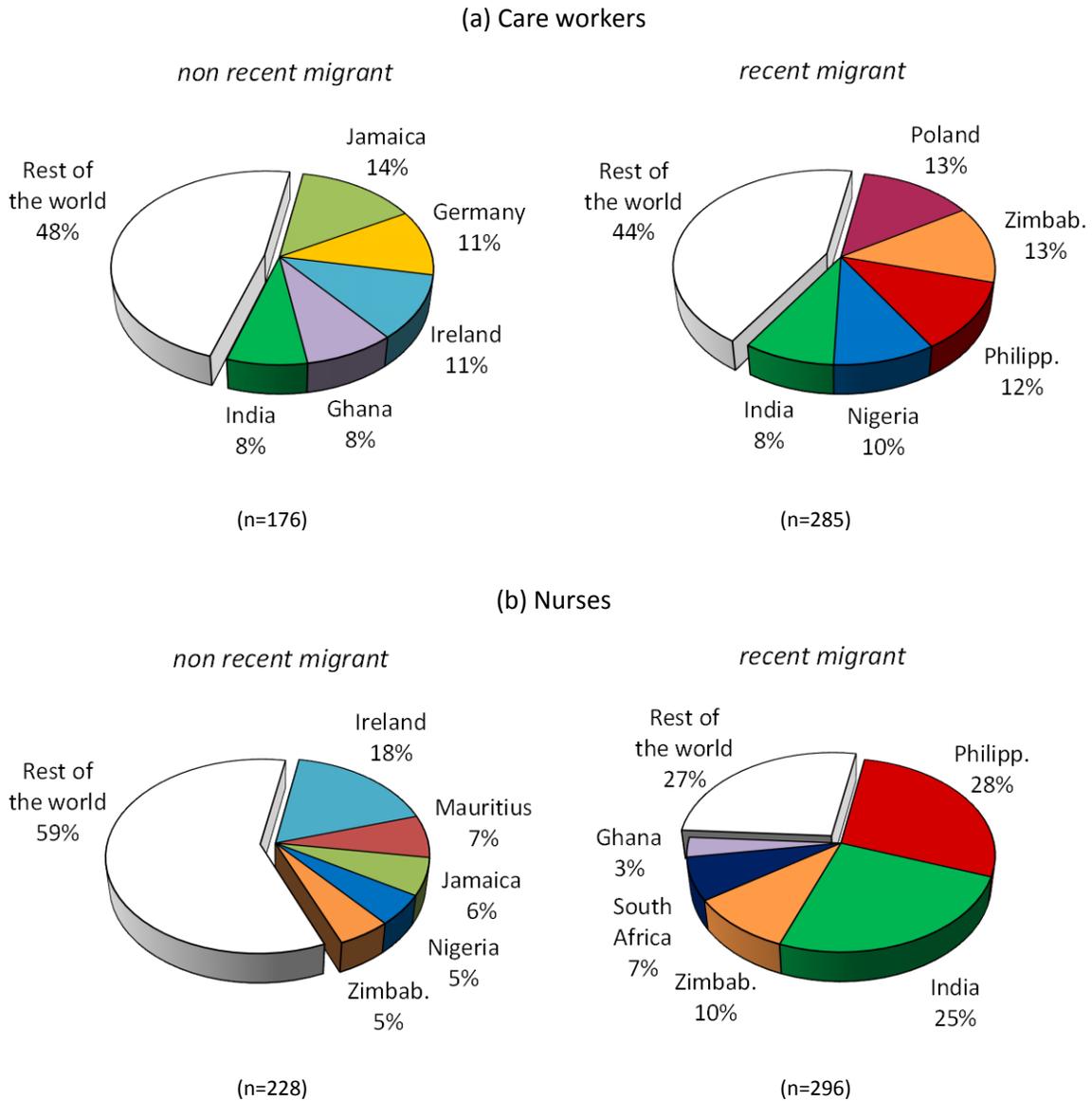
Source: Authors' elaboration on the Labour Force Survey.

Although these estimates have to be regarded with some caution because the coverage of the health and social care workforce by the LFS may have varied over time, they seem to suggest a clear trend, namely that migrants are playing an increasingly prominent role as care workers and nurses in the recent development of the health and social care workforce.

4.4 Countries of origin

Figure 4.5 shows the top five countries of birth of migrant nurses and care workers, with separate distributions for recent and non-recent migrants. As numbers for single countries of origin in the LFS sample are small, the breakdown should be taken as a general indication only. It should also be remembered that – as for the retrospective information on the year of entry – this figure provides only a general idea of the origin of past migrants who worked as care workers and nurses because it does not capture the relative incidence of return migration and occupational mobility among the various groups.

FIGURE 4.5: TOP FIVE COUNTRIES OF BIRTH OF FOREIGN BORN CARE WORKERS AND NURSES, BY PERIOD OF ENTRY, 2007/8



Source: Authors' elaboration on the Labour Force Survey.

Two main facts can be inferred from the chart. First, areas of origin have changed over time. Second, while some countries of origin are the same for the nursing and care workforce (e.g. Philippines, India, several African countries and, in the past, Ireland and Jamaica), their relative importance varied across occupations.

As far as migrant care workers are concerned (figure 4.5a), Eastern Europe – Poland in particular – and sub-Saharan Africa were the major areas of origin of recent flows. As a matter of fact, in the past decade migrants from Zimbabwe, Poland and Nigeria have overtaken those from Ireland, Germany⁴⁸ and Jamaica as the three largest groups of new arrivals.⁴⁹ In particular, after the 2004 EU enlargement Poland became the main source country of migrant carers.⁵⁰ The Philippines and India are also among the main source countries, but their proportion of the migrant workforce is lower than for nurses. The top five countries account for half of the inflow of recent migrants – i.e. the origin of flows is more diverse than for migrant nurses, reflecting the less regulated migratory patterns.

Looking at the distribution by country of origin of migrant nurses (figure 4.5b), it is striking that nowadays the most important source countries account for a much larger share of the flows than in the past: in particular, more than half of recent migrant nurses come either from the Philippines or from India. This is clearly an effect of the active recruitment policy based on bilateral agreements with these two countries enacted since the second half of the 1990s, as opposed to the more ‘spontaneous’ flows of the preceding decades.

Overall, the LFS breakdown by country of origin is consistent with our survey data in identifying the main sending countries.⁵¹ Migrant care workers employed by the surveyed organizations come mainly from Poland and the Philippines and to a lesser extent from India, Zimbabwe and other African countries.⁵² The main source countries reported for nurses are India and the Philippines – by a long way – followed by South Africa, Poland and Zimbabwe. In the follow-up interviews some employers reported that they have increasingly relied on EU migrants in order to cope with the increasingly stringent requirements to obtain and renew work permits for nurses and senior care workers coming from outside the EEA. Some of them also reported that in order to cope with the recent slowdown of migration flows from the 2004 accession

⁴⁸ Most care workers born in Germany have in fact British ancestry. Many of them are probably children of British soldiers who migrated back to Britain in the 1960s and 1970s, when the presence of the British army in the German bases was reduced.

⁴⁹ A comparison between the current stock of foreign born workers who entered the UK more than ten years ago – the ‘non-recent migrants’ in figure 4.5 – and the breakdown by country of origin of the care workforce recorded by the LFS in 1998 essentially confirms this picture, perhaps with Ireland playing an even more significant role in the flows of the past decades.

⁵⁰ Although the LFS figures are very small for such a short period, data from the WRS (see section 4.2) are consistent with this trend: 23,000 A8 nationals took up work as care assistants or home carers between 2004 and 2007 (Home Office 2009).

⁵¹ The number of participants in the survey providing detailed breakdown of the countries of origin of their migrant workforce was small. Therefore, estimates based on the LFS are likely to be more accurate.

⁵² The under-representation of the African and Caribbean groups in our survey data may be due to the low participation of organizations based in London, where these groups are concentrated.

countries they are employing increasing numbers of Romanians and Bulgarians entering the UK with self-employment or student visas.

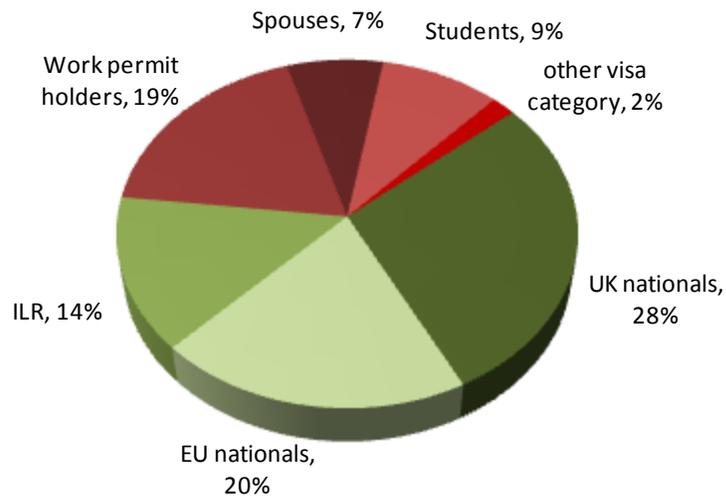
4.5 Immigration status

As will be clearer from the analysis presented in chapter 5, immigration status is a key dimension of migrant workers' employment patterns and career pathways. In very broad terms, it is important to make a distinction between those who have full rights to work in the UK – UK/EEA nationals and migrants with indefinite leave to remain – and those subject to some kind of restriction in their access to the labour market (work permit holders, students and some spouses). Although there are no data sources collecting information on the immigration status of migrant workers in the UK, a rough indication of the breakdown of the migrant care workforce can be obtained by combining LFS data on nationality and duration of stay with the information provided by the organizations participating in our survey on the main categories of migrants in their workforce.⁵³

The estimates presented in figure 4.6 should be regarded as very indicative, rather than precise, figures. They refer to the stock of migrant carers working in the UK in 2007/8 and *do not* represent the breakdown by immigration status on arrival: many migrants who are now British nationals or have indefinite leave to remain (ILR) may have entered the country as work permit holders, asylum seekers, students etc. Overall, the chart suggests that the immigration status of migrants working in the care sector varies across a broad range. One significant result is that about four in ten migrant carers belong to categories under immigration control and therefore may face restrictions in their access to the UK labour market. The estimated proportion of work permit holders (19 per cent) is broadly consistent with the administrative data on the number of new work permits issued to senior care workers (23,300 between 2001 and 2007).

⁵³ Our approach consisted of two steps. We first used the information on nationality and duration of stay from the LFS to estimate the proportion of UK and other EU nationals, and of migrants with indefinite leave to remain. The latter group was estimated assuming that all non-EU nationals who have been in the UK for five years or more have obtained the right of permanence residence. The second step consisted in estimating the breakdown of the residual group (non-EU nationals who have been in the UK for less than five years and are therefore subject to immigration controls) by main visa categories. We used the information provided by employers participating in our survey about the proportion of organizations employing migrants with different types of visas and relied on the assumption (plausible but not necessarily true) that the breakdown of the migrant workforce reflected the proportions of organizations reporting that they employ migrants of the different visa categories. For example, because the proportion of employers saying that they employed work permit holders was twice as high as that for students, this is reflected in the breakdown of the migrant workforce by a proportion of work permit holders (19 per cent) twice as high as that for students (9 per cent).

FIGURE 4.6: ESTIMATED BREAKDOWN OF THE FOREIGN BORN CARE WORKFORCE BY IMMIGRATION STATUS, 2007/8

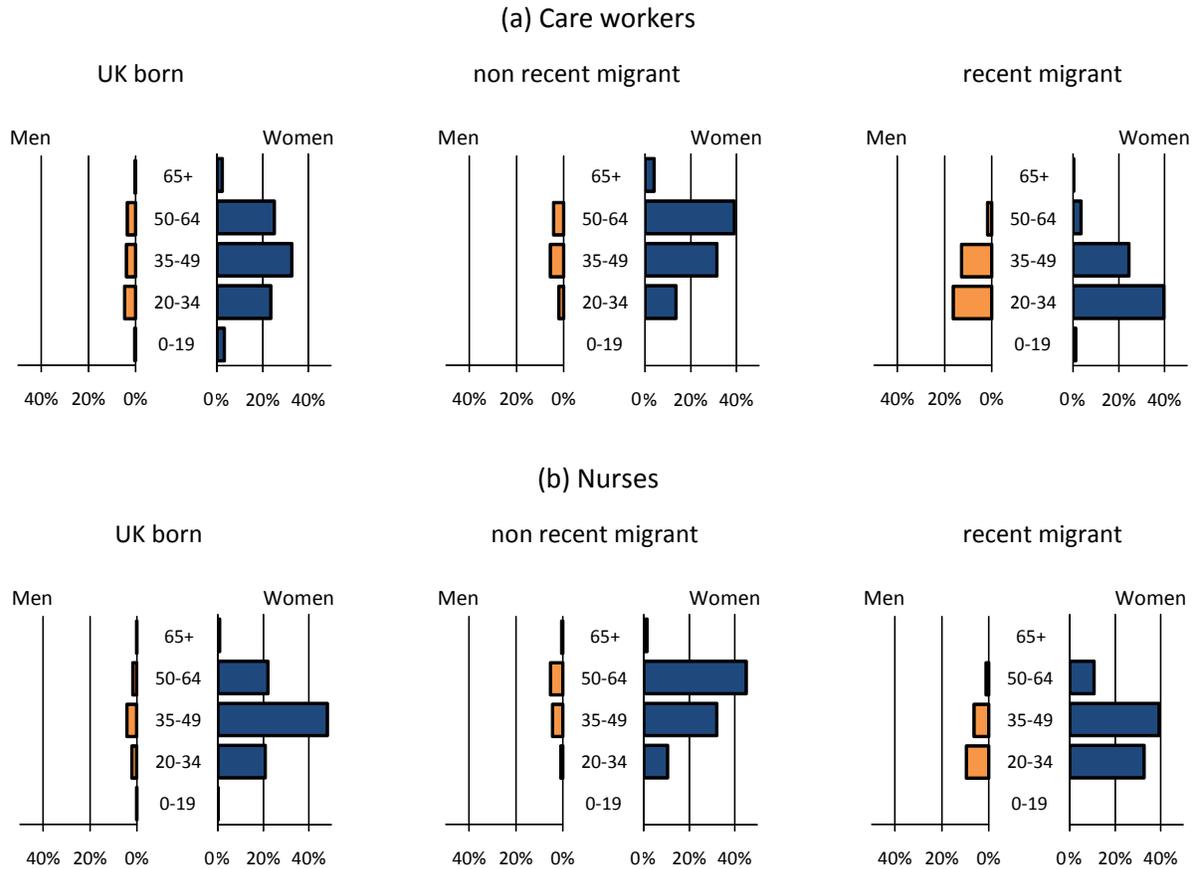


Source: Authors' estimates based on LFS and COMPAS survey data.

4.6 Demographic profile

The comparison of the age and sex distributions of the UK born and foreign born workforce shows interesting similarities and differences. The significant gender imbalance which traditionally characterizes nursing and social care occupations is reproduced by the migrant workforce – both care workers and nurses (see figure 4.7, a and b). However, the predominance of women is less pronounced among recent migrant care workers: men account for 31 per cent of those who arrived in the past decade, but only 13 per cent of UK born workers. The less unbalanced gender structure of recent migrants joining the social care workforce may be one of the factors behind the observed trend towards a higher proportion of men among recent entrants in the overall workforce measured by the NMDS-SC (see section 2.3.2).

FIGURE 4.7: AGE AND GENDER BREAKDOWN OF CARE WORKERS AND NURSES, UK BORN AND FOREIGN BORN BY PERIOD OF ENTRY, 2007/8



Source: Authors' elaboration on the Labour Force Survey.

The age breakdown shows particularly striking differences between the long-established migrant workforce and the recent arrivals. For example, 56 per cent of recent migrant care workers are in the 20–34 age group, while this is the case for only 16 per cent of non-recent migrant carers. Non-recent migrant care workers are over-represented among the 50–64 age group (43 per cent) – while UK born care workers are more evenly distributed across age groups, with a peak in the central age range (35–49). Similar age patterns characterize UK born and foreign born nurses, apart from a higher concentration of recent migrants in the 35–49 age group – which is not surprising in view of the longer training and possibly time-consuming adaptation procedures needed to work as a nurse.

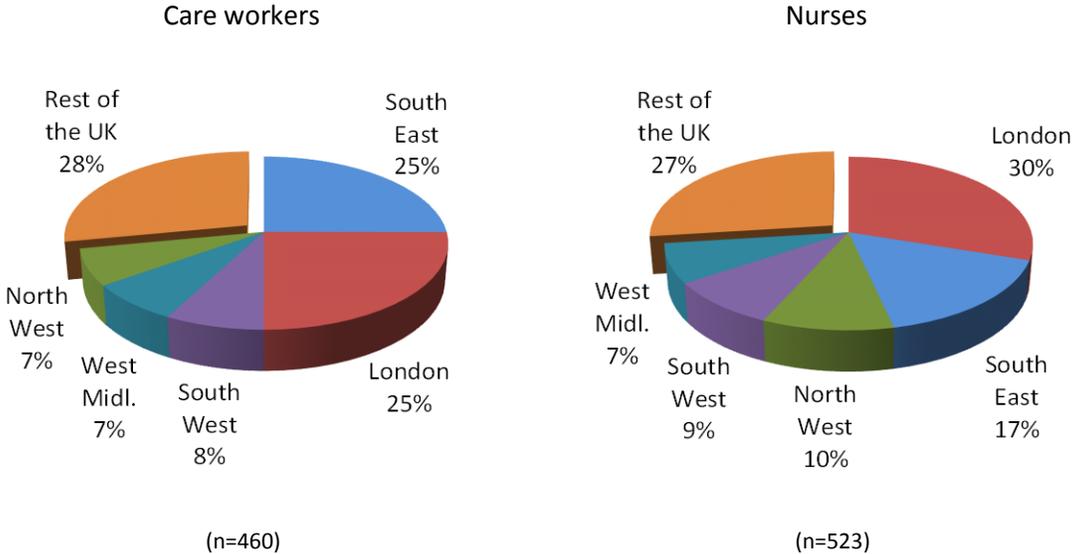
The younger age structure of recent migrant care workers is likely to have significant implications for their wages and employment patterns – reviewed at the end of this chapter.

Assuming age as a proxy for work experience and seniority, the younger demographic profile of recent arrivals is likely to explain, at least to some extent, their lower pay rates and over-representation in the more disadvantageous jobs.

4.7 Region of work

The distribution of migrant care workers and nurses across the UK is very uneven, with a high concentration in the south of the country. In fact, London and the South East are by far the main regions of work for both categories of workers, hosting about half of the migrant workforce. London stands out as the main destination among migrant nurses, while a comparatively larger share of migrant carers work in the South East (figure 4.8). The South West, the North West and the West Midlands are other important destinations.

FIGURE 4.8: DISTRIBUTION OF FOREIGN BORN CARE WORKERS AND NURSES ACROSS UK REGIONS, 2007/8



Source: Authors' elaboration on the Labour Force Survey.

This regional distribution is very similar to that of the whole foreign born population in the UK, which is probably related to the fact that many migrants – particularly care workers – move to the UK for non-economic reasons and enter the country through non-labour immigration channels. It also reflects the large presence of residential care institutions in the south of England, which is a popular retirement area.

Although the LFS sample is too small to enable us to estimate the regional distribution of migrant care workers and nurses by country of birth, different regional patterns for the main national groups are evident from the data set. For example, African and Caribbean care workers are essentially based in London (Zimbabweans also in the South East), Filipinos appear to be more concentrated in the south, and Indians and East Europeans are more evenly spread across the UK.

The uneven distribution across the country corresponds to even larger differences in terms of contribution of migrants to the local workforce (figure 4.9). The proportion of foreign born workers is by far the highest in London – as high as 60 per cent within both the nursing and the social care workforce (figure 4.9a). Migrants also account for a higher share of all care workers in the South East (one in four workers) than in other UK regions. This high territorial concentration in London and the South East means that in the rest of the UK the proportion of migrant carers in the workforce is below – sometimes well below – the national average, ranging from 14 per cent in the West Midlands to 7 per cent in Wales. Likewise, the share of migrants in the nursing workforce is very low in some regions in the north of the country – e.g. around 10 per cent in Scotland and the North East.

One interesting aspect of the regional distribution of migrant workers is that while in some areas the employment of migrant workers in health and social care is not a new phenomenon (over half of the migrant nurses in London entered the UK more than a decade ago), other regions have only recently manifested or significantly expanded their demand for foreign born workers. Looking at the proportion of recent migrants in the nursing workforce, it becomes apparent that the regions with the lowest incidence of migrant nurses are those in which recent arrivals account for a larger part of the workforce (e.g. Scotland and the northern regions). As far as care workers are concerned, beside some of the major receiving areas (e.g. the South East and outer London), where the numbers of migrants employed in the sector have increased markedly, other regions of the north of England as well the other UK nations are only recently experiencing a rising proportion of migrants in the social care sector. This evidence suggests that, although migrant nurses and care workers are still sharply concentrated in the southern regions, their employment is becoming a more common practice throughout the country.

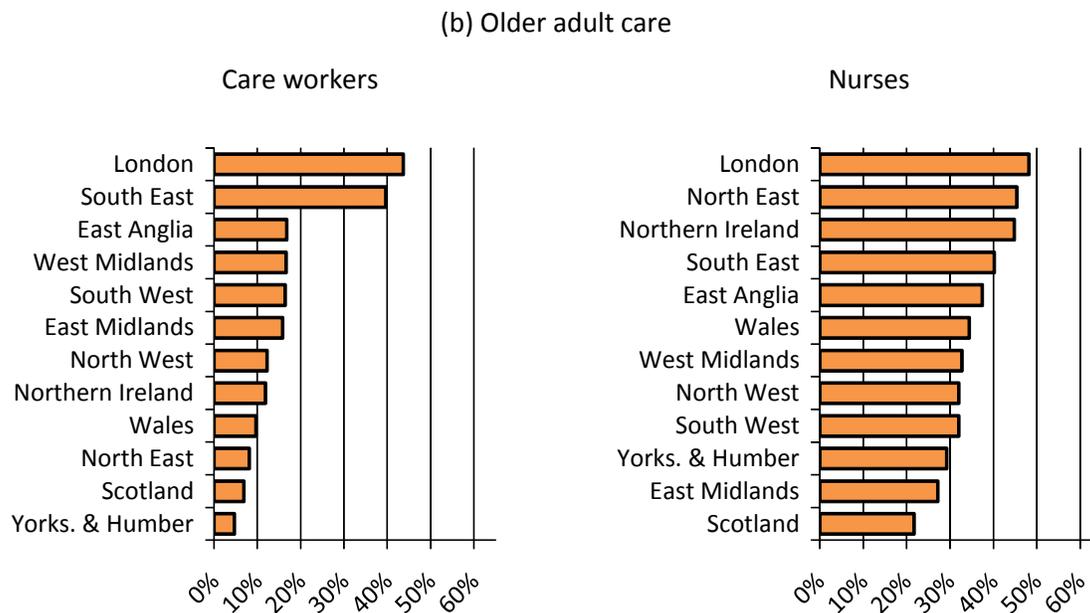
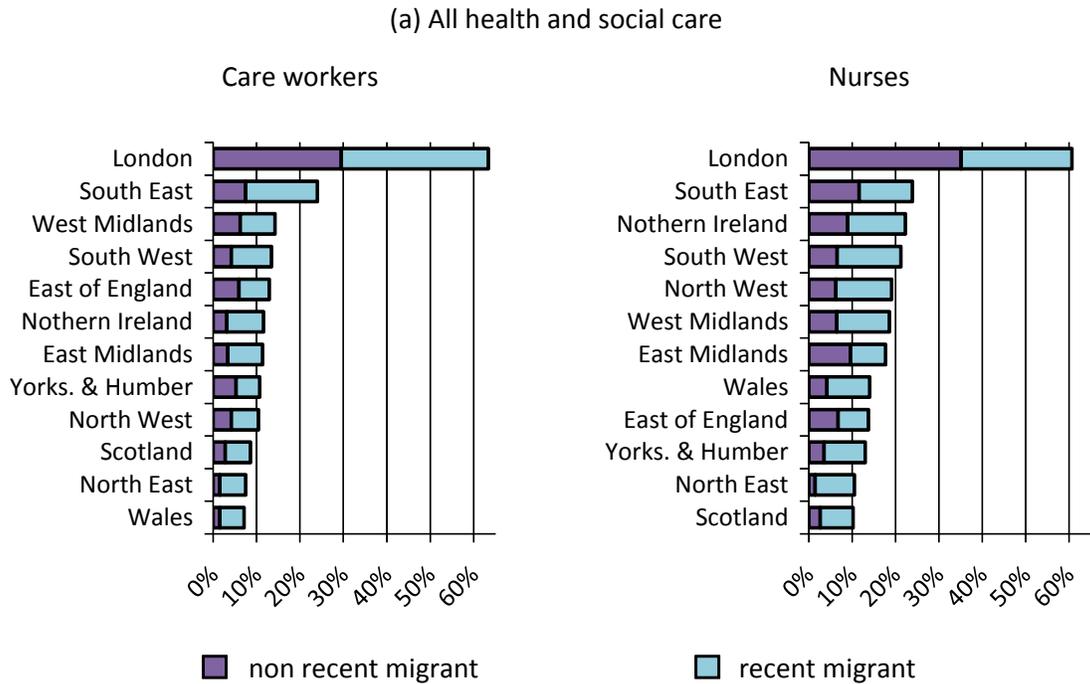
Regional estimates based on our survey referring to the proportion of migrants in residential care for older people (figure 4.9b) present a rather different picture from the LFS figures, which refer to the overall workforce in adult care services. Particularly striking is the much larger proportion of migrants reported by organizations based in the South East, although it is likely that this result depends to some extent on a mismatch of the regional breakdown – i.e. some respondents based in locations belonging to the Outer London area according to the classification of Government Office Regions may have reported themselves as based in the

South East. Other regions where the proportion of migrants working with older people may be higher than is suggested by LFS estimates are the South West, East Anglia, the East Midlands and Wales. All these areas apart from the East Midlands have relatively old resident populations, which may explain the higher reliance on migrants in the care of older people.

As far as nurses are concerned, estimates based on our survey are only indicative because of the small numbers involved when the breakdown by region is considered. Overall, they seem to confirm that migrant nurses are over-represented in residential care for older people in all UK regions (figure 4.9b). However, although London remains the area with the highest proportion of migrant nurses, the gap between the capital and other areas of the country is much smaller for this type of service, suggesting that a high reliance of the residential care sector on migrant nurses is a widespread phenomenon across the UK.

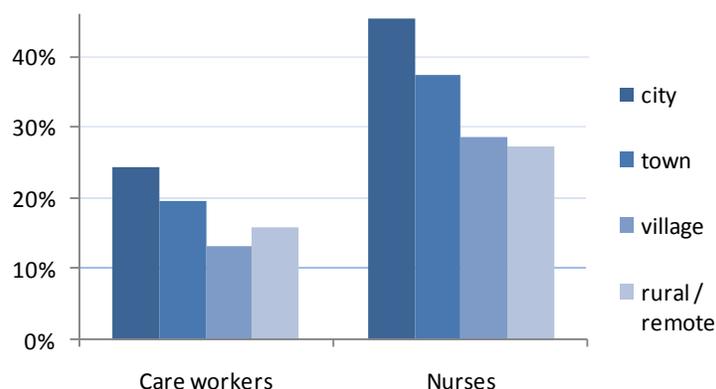
Regional statistics based on Government Office Regions conceal a great deal of variation within regions. The most obvious is the difference between metropolitan and rural/remote areas. This is shown by data collected through our survey, which provides information on the type of locality where the surveyed organizations are based. We found remarkable rural/urban differences in terms of proportion of migrants in the workforce (figure 4.10). The presence of migrant care workers and nurses is larger within organizations based in big cities, and is generally less significant the smaller the built-up area where the organization is located. This reflects the typically higher attractiveness to migrants of urban areas where they can more easily find work opportunities and larger social networks.

FIGURE 4.9: PROPORTION OF MIGRANT CARE WORKERS AND NURSES IN THE WORKFORCE BY REGION, 2007/8



Source: Authors' elaboration on the Labour Force Survey and COMPAS survey of employers (2008).

FIGURE 4.10: PROPORTION OF MIGRANT CARE WORKERS AND NURSES IN THE RESIDENTIAL OLDER ADULT CARE WORKFORCE BY TYPE OF METROPOLITAN AREA, 2008



Sample: 557 residential and home care organisations employing 13,846 care workers and 1,867 nurses.

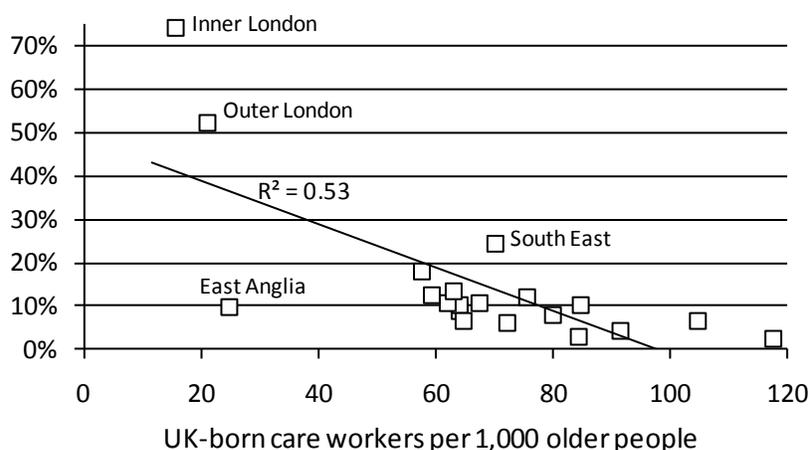
Source: COMPAS survey of employers (2008).

As mentioned above, the important role of social networks in the migration choices of nurses and care workers is confirmed by the fact that their geographical distribution within the UK is very similar to that of the whole migrant population – although the proportion of foreign born workers in these occupations is generally higher than their proportion in the rest of the workforce, which suggests that the health and social care sectors are among the industries with a higher demand for migrant workers all over the UK.

However, other factors also influence the geographical distribution of migrant care workers. One, mentioned above, is the age structure of the resident population: there is a positive correlation between the concentration of older people and the employment of migrants in social care. Another factor is – unsurprisingly – the local ‘availability’ of UK born workers. In aggregate terms this can be measured by the ratio of UK born care workers to the number of older people living in the region – under the assumption that they are the main users of care services. As expected, there is an inverse relationship between the proportion of migrants in the social care workforce and the number of UK born care workers per head (figure 4.11).⁵⁴ In other words, there is an element of complementarity in the geographical distribution of the UK born and migrant care workforces in social care: the lower the supply of UK born workers, the higher the proportion of migrants.

⁵⁴ There is likely to be some degree of correlation between the number of UK born care workers and their proportion in the workforce (as opposed to migrants) which could make the inverse relationship displayed in figure 4.11 appear stronger than it is. However, since care is for the vast majority provided informally within families, the per capita number of (paid) UK born care workers in a local area is affected much more strongly by the patterns of family care across regions than by the availability of other paid workers.

FIGURE 4.11: PROPORTION OF FOREIGN BORN CARE WORKERS (Y-AXIS) BY NUMBER OF UK BORN CARE WORKERS PER 1,000 OLDER PEOPLE (X-AXIS), BY UK REGION, 2007/8



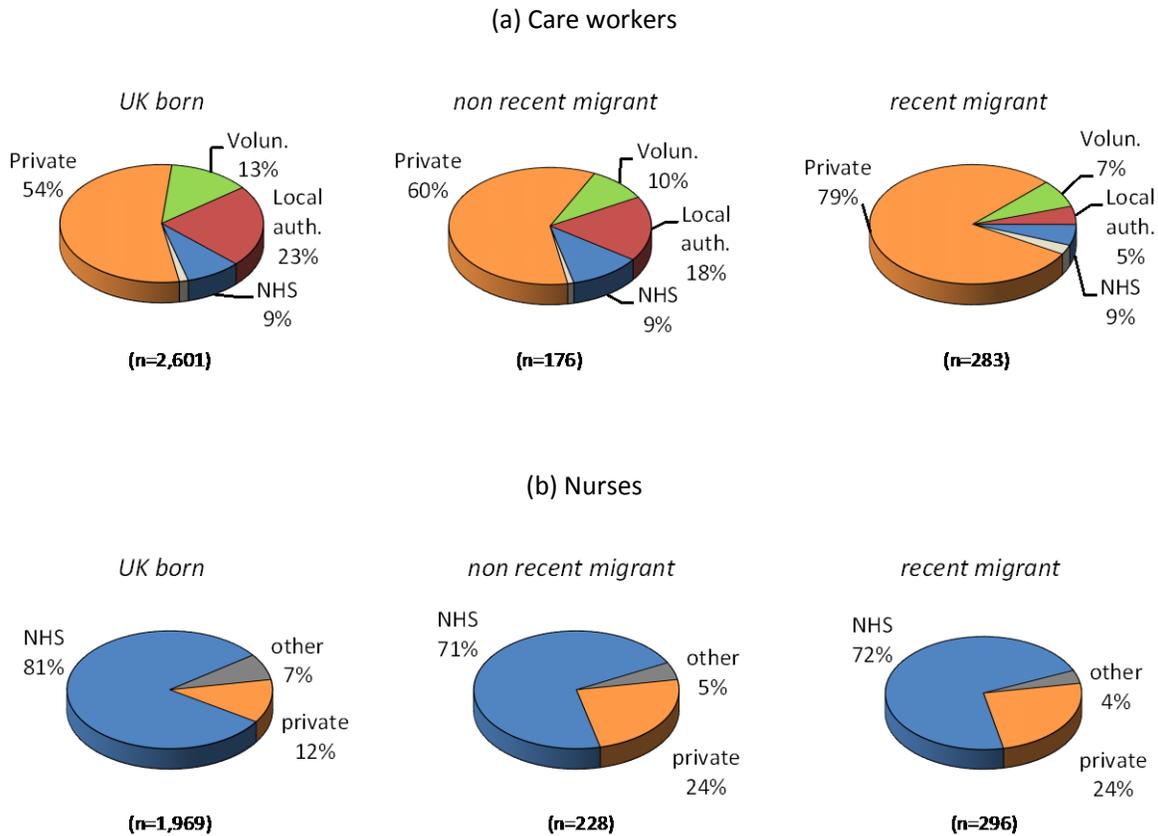
Source: Authors' elaboration on the Labour Force Survey.

4.8 Sector and service

The migrant workforce is not evenly distributed across the different organisations and services. As most social care providers in the UK operate as private enterprises, it is not surprising that the private sector is the main employer of both UK born and foreign born care workers (figure 4.12a). However, recent arrivals are far more strongly concentrated in the private sector than the UK born and long-established migrant workforce: 79 per cent of recent migrant workers are employed by a private organization, while this is the case for just above half of UK born workers. Within the workforce employed outside the private sector it is particularly worth noting the very low representation of recent migrant carers in local authorities (only 5 per cent, compared to 23 per cent of UK born care workers). The higher proportion of the long-established migrant workforce employed by local authorities (18 per cent) seems to suggest that migrant carers who work in the country for long periods experience some 'upward' labour mobility, i.e. they reach the more attractive jobs in the public sector.⁵⁵ Local authorities are also more likely to employ migrants in professional posts (e.g. as social workers) (Moriarty 2008). Interestingly, the proportion of the workforce employed by the NHS is constant for UK born and migrant workers (irrespective of their period of entry).

⁵⁵ This result has to be taken with some caution because cross-sectional retrospective data are not entirely suitable for assessing individual pathways over time. While some degree of career mobility seems apparent from the data, only further analyses based on longitudinal data sets could provide a better understanding of the work experiences of migrant carers who spend long periods of their working life in the UK.

FIGURE 4.12: DISTRIBUTION OF CARE WORKERS AND NURSES BY SECTOR, UK BORN AND FOREIGN BORN BY PERIOD OF ENTRY, 2007/8



Source: Authors' elaboration on the Labour Force Survey.

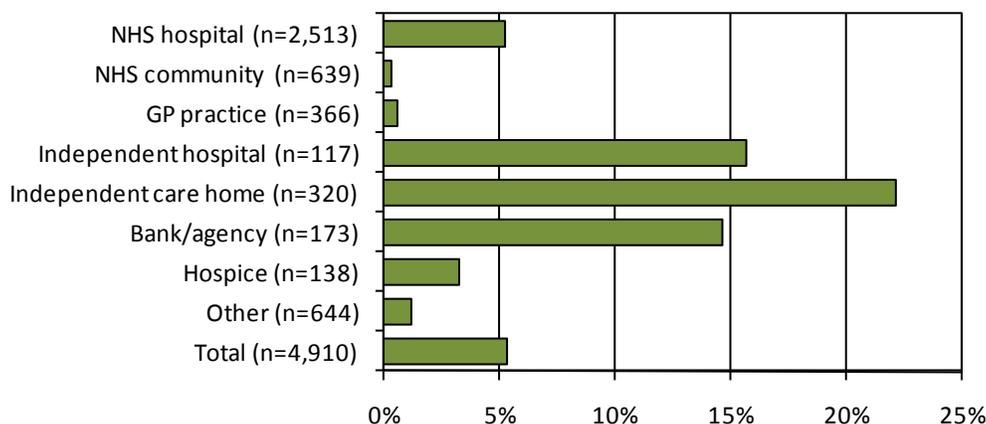
As far as foreign born nurses are concerned (fig. 4.12b), most of them work in healthcare, and the NHS is by far the main employer – about 80 per cent of UK born nurses and 70 per cent of migrants according to LFS data. Nevertheless, migrant nurses too appear to be over-represented in the private sector: one in four of them works either for a private hospital, nursing home or nursing agency.

The higher proportion of migrant nurses employed in the private sector has been well documented by surveys commissioned by the Royal College of Nursing (RCN). Although their target group are internationally recruited nurses (IRNs) which is a much narrower definition than that used in this report for the foreign born workforce,⁵⁶ the RCN survey also shows the

⁵⁶ Internationally recruited nurses (IRNs) are defined as nurses who qualified overseas and started working in the UK in the six years before the survey – i.e. between 1999 and 2005 (Ball and Pike 2007a).

high over-representation of IRNs in the independent (private + voluntary) sector (figure 4.13). IRNs make up an especially high proportion of the nursing workforce in independent care homes (22 per cent), independent hospitals (16 per cent) and banks/agencies (15 per cent) – in comparison with 5 per cent in the NHS. The RCN survey also found that IRNs were more likely than others to work full-time and have second jobs, and to be dissatisfied with current working conditions and willing to move to the NHS; but a higher proportion were unsuccessful in applications for higher-grade posts (Ball and Pike 2007a).

FIGURE 4.13: PROPORTION OF INTERNATIONALLY RECRUITED NURSES^a IN THE WORKFORCE BY TYPE OF ORGANISATION, 2005



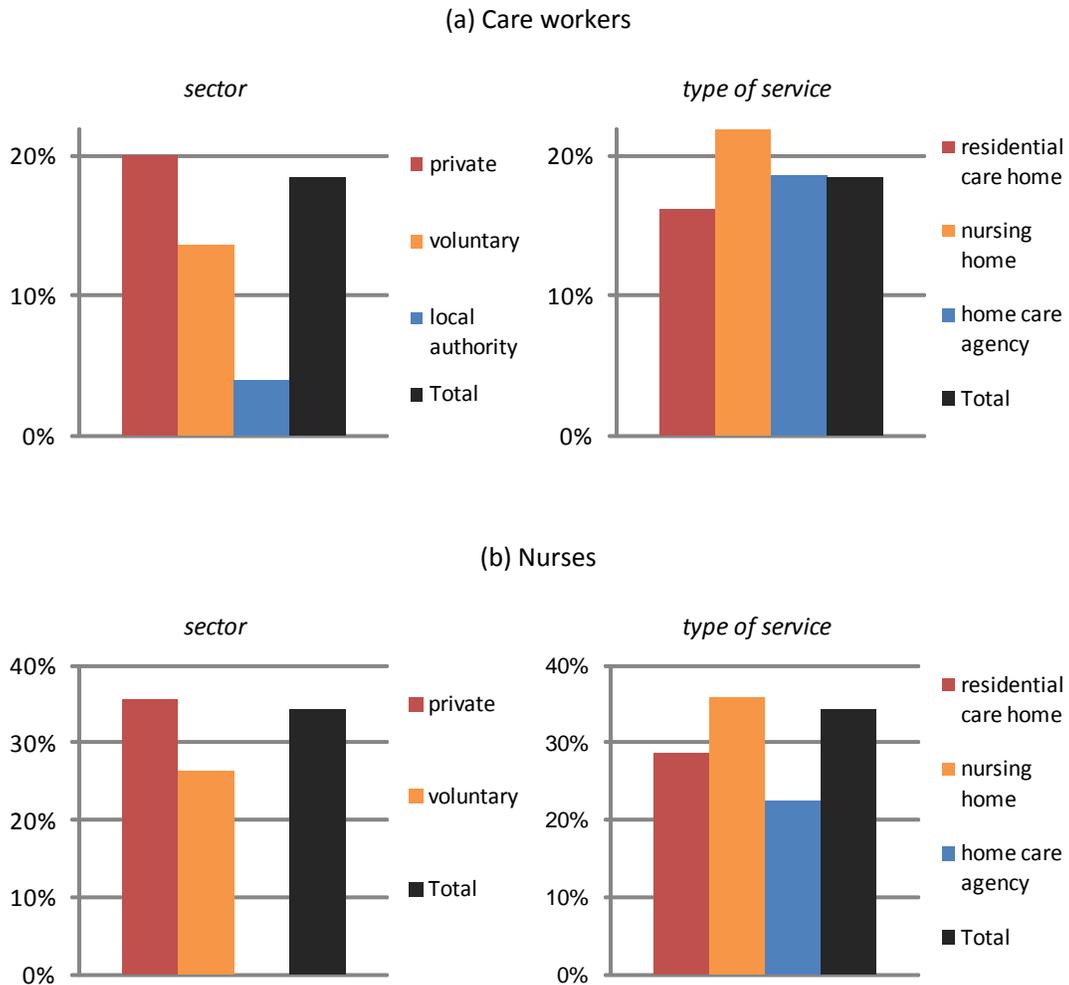
^a Nurses who qualified abroad and started working in the UK in or after 1999.

Source: Authors' elaboration from table 5 in Ball and Pike (2007a, p.8).

Estimates from the COMPAS survey of organizations caring for older adults also confirm the higher concentration of migrant care workers and nurses in the workforce employed by private businesses (figure 4.14).⁵⁷ They also provide additional information on the employment of migrants across different types of services. This breakdown suggests that both migrant care workers and nurses are over-represented in nursing homes as compared with care homes without nursing facilities.

⁵⁷ The very low representation of the migrant workforce within local authorities (4 per cent) is especially remarkable. Although this estimate is unreliable because of the very small number of care homes managed by local authorities participating in the survey (16), the substance of the result and its order of magnitude are essentially consistent with the LFS estimates.

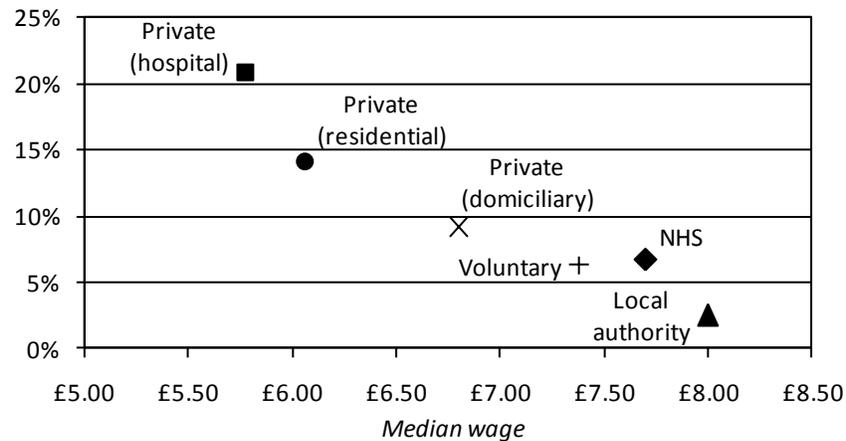
FIGURE 4.14: PROPORTION OF MIGRANT CARE WORKERS AND NURSES IN THE OLDER ADULT CARE WORKFORCE, BY SECTOR AND TYPE OF SERVICE, 2008



Source: COMPAS survey of employers (2008).

As mentioned earlier in this report, the reasons why recent migrants are concentrated in the private sector and why the long-term resident workforce prefers to work within local authorities or the NHS are to be found in the better wages and working conditions available in the public sector. Figure 4.15 – based on LFS data – displays the relationship between the proportion of recent migrant carers and the median wage levels in the different sectors and types of organizations. It shows that:

FIGURE 4.15: PROPORTION OF RECENT MIGRANT CARE WORKERS AND MEDIAN GROSS HOURLY WAGE BY SECTOR AND ACTIVITY^a, 2007/8



^a Type of activity for the private sector are based on SIC 2003 classification. Categories used in the figure are: Hospital activities (85.11), Social work with accommodation (85.31) and Social work without accommodation (85.32).

Source: Authors' elaboration on the Labour Force Survey.

- There are significant wage differentials between the public and the private sectors. Median wages range from £5.80 in private hospitals to £8.00 an hour in local authorities, the voluntary sector lying in between. Wage levels are higher in domiciliary care (£ 6.80) than in residential care (£ 6.10).
- The reliance on recent migrant care workers is higher in sectors and services with lower pay levels (particularly in private care homes, including nursing homes, and private hospitals) and lower in the sectors and type of organizations with comparatively higher wages – local authorities, the NHS and voluntary organizations).

A similar pattern is observable for nurses, i.e. the over-representation of recent migrant nurses in the private sector can be associated with pay levels generally lower than in the NHS.

This evidence suggests that the pay structure in health and social care is an influential variable which affects the demand for migrant labour. In fact resident workers, including the long-established migrant workforce, tend to concentrate in the sectors and activities offering better economic conditions, thus leaving a larger pool of unmet demand in the less desirable jobs. The greater presence of non-recent migrants in the sectors where pay is higher seems to show also that migrant workers who stay in the social care labour market move from the private to the public sector when the opportunity arises.

4.9 Employment patterns

The rest of this chapter reviews employment and working conditions in social care. In order to narrow down the scope of the analysis and target as much as possible the workforce employed in care of older adults, we excluded from our pooled LFS sample workers employed by the NHS. As the number of nurses employed outside the NHS included in the LFS sample is too small to allow comparison of the migrant and UK born workforce, we decided to focus the rest of the analysis in this chapter on care workers.

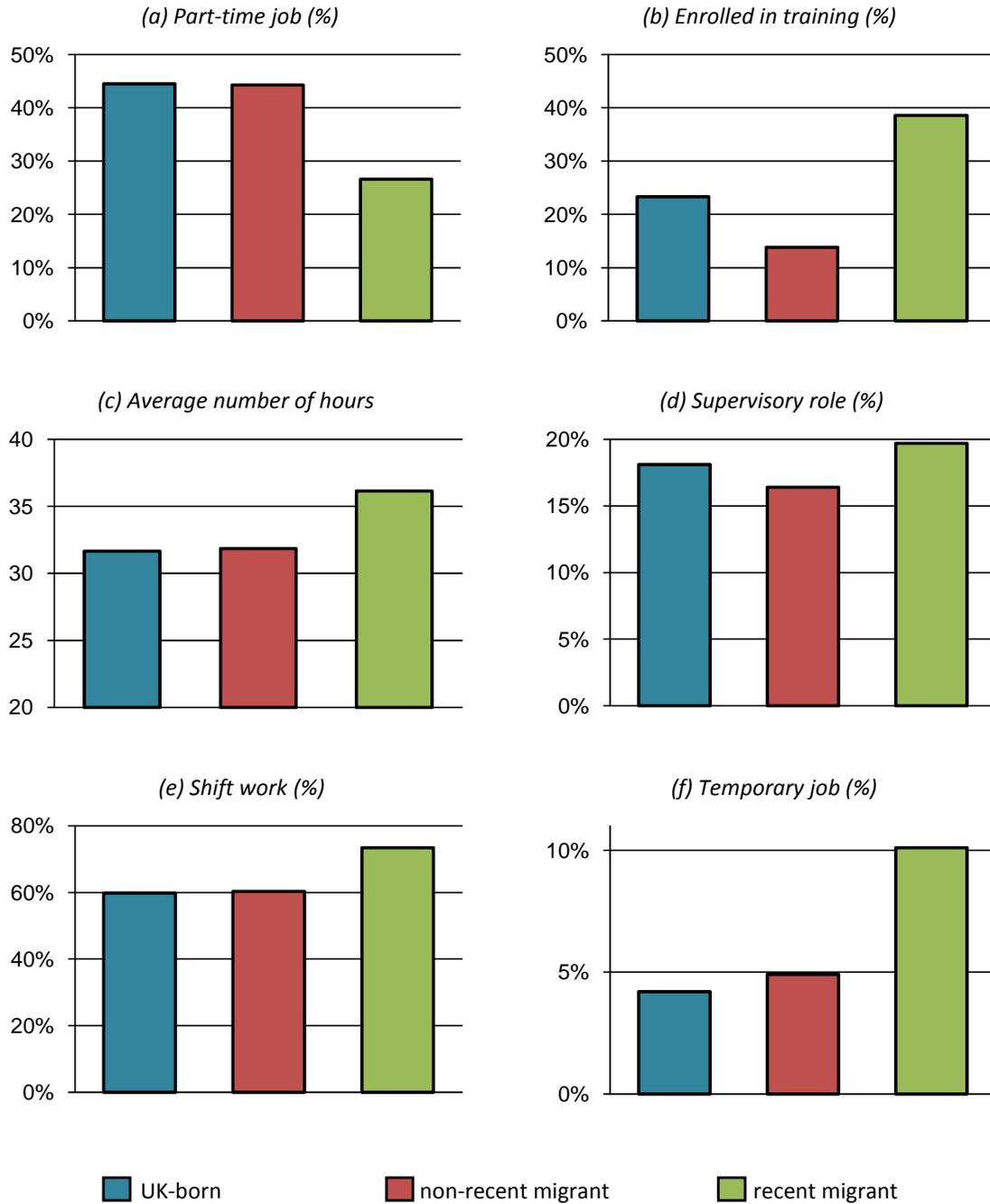
Figure 4.16 compares the employment patterns of UK born, recent migrant and non-recent migrant care workers on the basis of key indicators drawn from LFS data. Overall, it shows that there are no significant differences between the UK born workforce and migrants who have been working in the UK for a long time, while recent migrants display somewhat different patterns in relation to both their contractual arrangements and their working conditions.

Migrant carers who recently came to the UK are less frequently found in part-time jobs (figure 4.16a). About one in four of them work part-time in the main job, while this is the case for almost one in two UK born and long-established foreign born workers. It is also worth emphasizing that recent migrants may have different reasons for taking up part-time employment from the rest of the workforce. While at least four out of five UK born and long-established migrant resident care workers work part-time because they do not want full-time employment, this is the case for only about half of the newcomers. Many recent migrants who work part-time (38 per cent) do so because they are enrolled in further training or education.

A higher propensity on the part of migrant carers to work full-time is confirmed by our survey for the older adult care sector: only 31 per cent of the migrant workforce employed by the surveyed organizations was part-time, compared with 52 per cent of the UK born carers. The survey pointed to an even larger gap between migrant and UK born nurses working with older people (27 per cent against 54 per cent of part-timers respectively).⁵⁸ For both migrant care workers and nurses, part-time work is especially widespread in the voluntary sector and within small organizations.

⁵⁸ One reason for this may be that more migrant nurses than care workers entered the UK on a work permit issued for and bound to full-time employment. This would also explain the extremely low proportion (about 10 per cent) of part-time workers among internationally recruited nurses found by the RCN survey (Ball and Pike 2007a). In fact the majority of nurses within this category – defined as nurses who qualified abroad and started working in the UK in the six years before the survey was conducted – are likely to be on work permits issued for full-time jobs.

FIGURE 4.16: EMPLOYMENT PATTERNS OF CARE WORKERS, UK BORN AND FOREIGN BORN BY PERIOD OF ENTRY, 2007/8



Source: Authors' elaboration on the Labour Force Survey.

Enrolment in training, identified above as the rationale behind the part-time employment of many recent migrant care workers, seems to be a general feature of the recently arrived foreign born workforce (figure 4.16b). In fact all recent migrant care workers are more likely than the long-term resident workforce to be enrolled in training: 39 per cent of recent arrivals are studying towards a qualification, compared to 23 per cent of the UK born workforce. One reason for this can be found in the younger age profile of recent migrants (figure 4.7). Of those enrolled in some training – both migrants and non-migrants – about three out of four workers are studying for a qualification in nursing and care or a health/social care related subject. One in four of the students would thus appear to be working in the care sector in order to support study in unrelated subjects.

The differences in the propensity (or opportunity) to take up part-time work are mirrored by the higher average number of weekly hours worked by recent migrants (fig. 4.16c). On average, recent migrants work nearly five hours per week more than UK born carers. Over 30 per cent of them work more than 40 hours a week, compared with 18 per cent of UK born carers. These differences are perhaps smaller than one would expect looking at the proportions of part-timers, but this may be explained by the greater involvement of recent migrants in training activities.

There is little difference between migrants (both the ‘new’ and the ‘old’ arrivals) and the UK born carers in terms of proportion of the workforce in the more senior positions: about one in five of both groups have supervisory roles (figure 4.18d).

As one might expect, recent migrant carers – who are on average younger and have less UK work experience – are more likely to be found in the jobs offering less advantageous working conditions. For example, a larger proportion of newcomers (74 per cent) do shift work either occasionally or regularly – although this is a pattern also common to the majority of the long-term resident workforce (figure 4.18e).

Newcomers are also twice as likely as UK born and non-recent migrant workers to have temporary contractual arrangements, but the proportion of those who do not have a permanent job remains rather low at about 10 per cent (figure 4.18f).

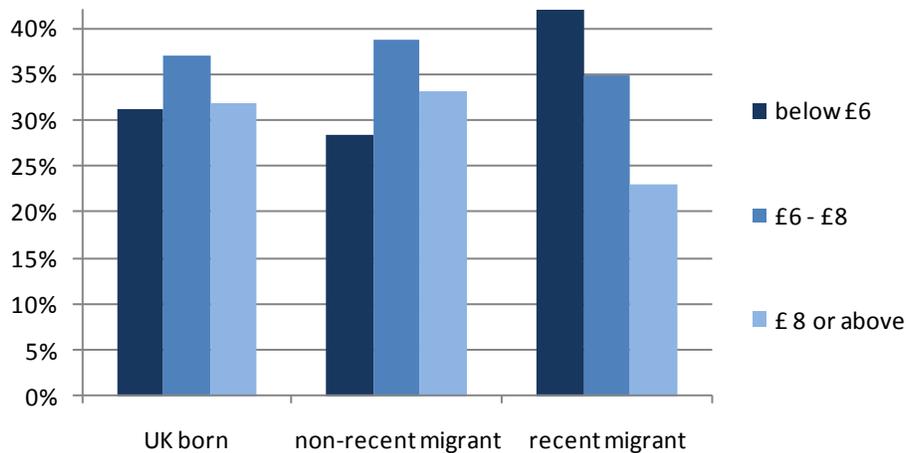
4.10 Pay

Figure 4.17, based on LFS data,⁵⁹ compares the distribution of the UK born and foreign born care workforce across the wage spectrum. Although some caution is needed in the

⁵⁹ Based on the LFS derived wage variable *hourpay*.

interpretation of LFS wage data because of significant differences from the estimates provided by other data sources (see section 2.3.3 above), the figure suggests a quite remarkable variation in the pay distribution of recent migrants in comparison with the UK born and long-established migrant care workforce. In particular, recent migrants are more concentrated in the lowest pay band: 42 per cent of them earn less than £6 an hour (before taxes), while this is the case for 31 per cent of the UK born workforce and 28 per cent of non-recent migrants. At the top of the wage spectrum, a smaller proportion of recent migrants – one in five – are paid £8 or more, compared with about one in three UK born and non-recent migrant carers.

FIGURE 4.17: WAGE DISTRIBUTION OF CARE WORKERS, UK BORN AND FOREIGN BORN BY PERIOD OF ENTRY, 2007/8



Source: Authors' elaboration on the Labour Force Survey.

This analysis refers only to 'gross' figures, i.e. it does not attempt to control for the measurable determinants of pay levels, such as age, education, type of employment (e.g. full-time or part-time), regional distribution and so on. This means that it remains unsettled whether the observed wage differentials can be fully explained on the basis of objective factors, or whether and to what extent there may be other rationales such as the presence of discriminatory employment practices by employers.

The over-representation of recent migrants in the lowest income classes is not surprising, as they are on average younger, have less UK work experience and are more likely to work in the private sector than the long-term resident workforce. It is nevertheless important to stress that, in a sector where low pay is common, recent migrant workers appear to be even more exposed to the risk of being underpaid than the domestic workforce. In particular, LFS data collected

from workers – as opposed to ASHE and NMDS-SC data based on information provided by employers – suggest that, in comparison with ‘official’ estimates for the care sector (see section 2.3.3), a higher proportion of recent migrants may be paid below the National Minimum Wage.

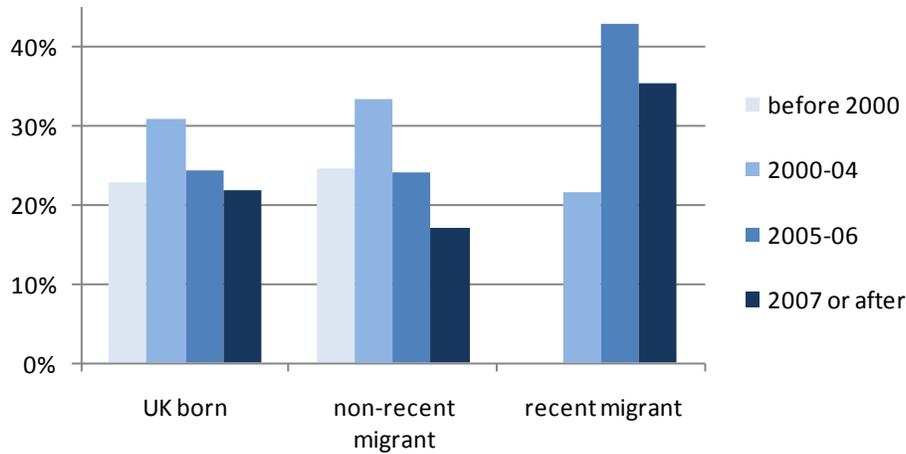
Although a comprehensive assessment of the factors underlying the lower pay levels of recent arrivals remains out of the scope of our analysis, this seems to be a key issue for understanding demand for migrant care workers which calls for further investigation.

4.11 Turnover

As mentioned in chapter 2, the social care workforce is characterized by high turnover rates relative to most other economic sectors. Figure 4.18 shows that, on the whole, UK born and long-established migrant carers display very little difference in terms of distribution by starting period of their current employment: between 20 and 25 per cent of both groups started to work for their current employer in or after 2007; and around 20 per cent of workers in both groups found their current job before 2000.

In contrast, the pattern of current employment duration looks completely different for migrant carers who began work in the UK in the past ten years. More than 40 per cent of them got their present job in or after 2007, and only 20 per cent started before 2005. These figures are not really comparable with the corresponding breakdown of the long-term resident workforce because within the group of recent migrants there are many care workers who entered the UK in the past couple of years and hence have been employed for a very short time. However, even after controlling for this bias the period of time spent by recent migrants in their current job remains on average lower. Including in the analysis only migrant carers who entered the UK before 2007, the proportion of those who started to work for the current employer in or after 2007 was 66 per cent for those who came in 2005–06, 39 per cent for those entering the UK between 2000 and 2004, and 34 per cent among those who arrived before 2000. Although these estimates are based on small samples, they are essentially consistent with the expectation that migrants, when given the opportunity, change job more frequently at the beginning of their careers in the UK.

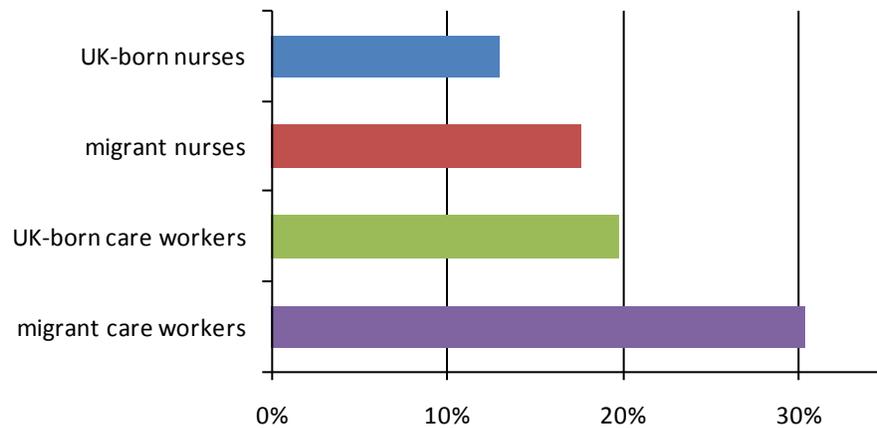
FIGURE 4.18: DISTRIBUTION OF CARE WORKERS BY STARTING PERIOD OF CURRENT EMPLOYMENT, UK BORN AND FOREIGN BORN BY PERIOD OF ENTRY, 2007/8



Source: Authors' elaboration on the Labour Force Survey.

The higher turnover rates of the migrant workforce are confirmed by our survey. The proportion of the workforce who left their job in the year preceding the survey is higher for care workers than for nurses, and, within these two occupations, for migrants compared to the UK born workforce (figure 4.19). Migrant carers have in fact very high levels of turnover, with nearly one in three workers having left their job in the past 12 months. This result is pretty steady across sector, type of area, and type and size of organization, though slightly higher levels are observed for home care providers and residential homes based in rural areas.

FIGURE 4.19: TURNOVER RATES OF UK BORN AND MIGRANT NURSES AND CARE WORKERS, 2008



Source: COMPAS survey of employers (2008).

The LFS sample of foreign born care workers is too small to look at the duration of current employment of single national groups. Our survey data points to higher turnover rates of migrant carers for organisations employing mainly A8 nationals than for organisations where most migrants employed come from outside the EEA. This suggests that immigration status play a role – i.e. retention is likely to be higher for work permit holders and other categories under immigration control because they face legal constraints when changing employers.

4.12 Conclusion

Evidence presented in this chapter shows that the influx of migrant workers in care occupations has increased at unprecedented levels since the mid-1990s. It is significant that about half of the current stock of migrant nurses and care workers have entered the UK since 2000. According to our survey of residential homes, nursing homes and home care agencies, migrants account for 19 per cent of care workers and 35 per cent of nurses employed in the care of older people, and for an even higher proportion of workers recruited during the year preceding the survey (28 per cent of care workers and 45 per cent of nurses).

In the past decade, most of these care workers have come from Zimbabwe, Poland, Nigeria, the Philippines and India. Since the 2004 EU enlargement, Poland has become by far the main country of origin of care workers, sending one in four of the new arrivals. However, WRS data for care assistants suggest that migration from the new EU member states is significantly decreasing. Although there are no exact figures on the number of A8 workers leaving the country, estimates suggest that return migration of East Europeans has become significant, with return rates around 40–50 per cent within a few years of arrival, and an acceleration of the pace of return in 2007 and 2008.

Evidence from both the LFS and our own survey of employers showed that the distribution of migrant carers across the UK is very uneven: they are highly concentrated in London and the south of the country, especially in large cities. This corresponds to remarkable differences in the proportion of migrants in the local workforce – from more than 60 per cent in London down to less than 10 per cent in some of the northern regions. However, this strong polarization seems to be mitigated by the most recent trends: some regions have recently manifested for the first time or significantly expanded a demand for foreign born workers, suggesting that the employment of migrant nurses and care workers is becoming a more common practice across the country. Also, we found a complementarity in the territorial distribution of migrants and UK born workers across the UK: the share of migrants in the workforce is higher where the supply of UK born care workers – measured as the ratio between the number of UK born care workers in the local workforce and the number of older people in the local population – is lower.

Migrant carers account for a much larger proportion of the workforce in the private sector than within local authorities, with the voluntary sector falling in the middle. Our analysis suggests that the significant variation in the demand for migrant workers by sector and type of organization is inversely related to average wage levels: that is, migrants are less well represented in the jobs which pay higher wages and provide more secure contractual conditions.

Recent migrants are over-represented in the lowest income bands. Although this may be related to their higher concentration in the private sector, younger age and shorter work experience in the UK, it remains to be determined whether the observed wage differentials can be fully explained on the basis of these factors, or whether and to what extent there may be other rationales such as the presence of discriminatory employment practices. Whatever the underlying factors, LFS data shows that recent arrivals are at greater risk than the UK born and long-term resident workforce of being paid below the National Minimum Wage. Although the significant variation between wage estimates based on different data sources makes it hard to be definite about the extent to which this actually happens, there is cause for concern and a need for further investigation.

In terms of employment patterns, we found no significant differences between the UK born workforce and migrants who have been working in the UK for a long time. In contrast, migrant carers who have come to the UK recently are less frequently found in part-time jobs and are more likely to be enrolled in training activities. Recent migrant carers – who are on average younger and have less UK work experience – are also more often found in the jobs offering less advantageous working conditions (e.g. shift work and temporary contracts), but the differences between this group and the UK born and long-established migrant workforce are moderate. Results from both our survey and our analysis of LFS data are also consistent in showing that migrant carers, if granted free access to the UK labour market, change job more frequently at the beginning of their career in the UK.

These characteristics of the migrant workforce are all relevant for an understanding of their patterns of incorporation in the UK care sector. As will be shown in the next chapter, they contribute to shape employers' preferences for migrant labour. That chapter will provide further evidence about the employment of migrants in the care of older people by looking at the factors affecting employers' demand, at the recruitment process and at the impact of immigration and care regulations.

5. The Recruitment and Retention of Migrant Care Workers

As shown in the previous chapter, the employment of migrant workers in the care sector has become very significant over the past decade. The main question we address in this chapter is why employers have increasingly turned to migrant workers to fill vacancies in this sector. We shall show that several factors have affected the increase in work opportunities for migrants, with employers' preferences, migrant workers' economic strategies, and the structural features of the immigration and care systems all playing important roles.

The chapter will begin with a discussion of the major factors responsible for the mismatch between labour demand and supply in the care sector, followed by a brief review of the literature on attitudes of employers towards migrant workers. We will then present the reasons for employing migrant workers reported by employers responding to our survey, and the recruitment strategies used to hire migrant carers both in the UK and overseas. In the last section, we will supplement the perspective of employers by giving an account of migrants' experiences of recruitment and employment in the care sector, showing in particular the interconnections between immigration status and the migrant pathways into and within the social care labour market.

5.1 Labour demand and supply in the care sector

As highlighted in chapter 2, the social care sector faces difficulties in recruiting and retaining care workers to meet current levels of demand for care, experiencing vacancy and turnover rates nearly double that for all types of industrial, commercial and public employment (Eborall and Griffiths 2008). The CSCI has described recruitment and retention in the sector as an area of 'chronic difficulties' (CSCI 2006b: 1).

Recent trends showed a sharp rise in the number of vacancies in the social care sector notified to Jobcentres in 2007 and 2008, mainly due to an increase in vacancies reported for care workers (CSCI 2009). This trend appears to have gone into reverse since the beginning of 2009, arguably because of the consequences of the current economic downturn – see section 8.3 below. Many of the vacancies in social care are termed 'hard to fill', and this difficulty is generally attributed to the existence of skills gaps (that is, to a shortage of suitably qualified candidates), rather than to an overall shortage of applicants (Learning and Skills Council 2006). The high levels of turnover in the social care workforce may be an even bigger challenge for employers, who find it hard to retain staff.

Understanding the reasons for these ‘chronic difficulties’ in recruitment and retention requires close consideration of a complex set of factors and their interrelationships. These factors are related to both the demand and the supply side of the labour market, i.e. to the number and type of jobs in the sector and to the size and characteristics of the workforce potentially available to take up these jobs. While a full account of the decision-making process behind employers’ and workers’ choices and practices and of the possible reasons for a mismatch between demand and supply is out of the scope of this report,⁶⁰ it is important to stress that there is a mutually conditioning relation between labour demand and supply: employer demand for labour aligns itself with supply just as labour supply adapts to demand. In other words, employers’ perceptions of workers’ motivations, constraints and frames of reference are likely to affect their strategies and practices of recruitment and employment (Anderson and Ruhs 2008).

Broadly speaking, in the social care sector the mismatch between labour demand and supply is mainly related to the unfavourable employment and social conditions of the jobs available on the market. Low wages, unsocial hours, temporariness, lack of career opportunities and low status can all prevent job seekers from applying for direct care positions (Moriarty 2008). While some of these factors (e.g. shift work) are intrinsic to the nature of the job, others might depend on the institutional structure of the care sector. In particular, the many independent organisations that rely on public funding to run their businesses may be subject to budgetary constraints that make it impossible to raise wages to attract more domestic workers. The regulatory requirements for minimum staffing may be a further restraint on the upward mobility of wages (Moriarty et al. 2008).

The unattractiveness of direct care jobs is also related to the socially constructed, often negative, perception of social care work. The perceived low status of jobs in care of the elderly can lead job seekers to prefer other types of jobs which offer similar wages and working conditions. Also, as the care sector workforce was traditionally made up of middle-aged women with no or poor formal qualifications, other types of job seekers, especially male unemployed, may disregard work opportunities in the care sector or consider themselves lacking in the personal skills required (Moriarty et al. 2008).

Mismatches between labour demand and supply are not necessarily quantitative (not enough people apply for the jobs on offer) but can also be qualitative (employers do not find candidates with the ‘skills’ they are looking for). This is a key issue in social care because the skills sought in this workforce consist in a wide range of qualifications and competencies, and ‘soft skills’ can be as important as formal qualifications such as NVQs. Also, the demand for soft skills can easily shade into a demand for personal characteristics and attitudes (Anderson and Ruhs 2008).

⁶⁰ An extensive review is provided by Anderson and Ruhs (2008) in their paper prepared for the MAC.

Finally, it is important to stress that the mismatches between labour demand and supply are concentrated in some areas of the country. Although there is moderate variation of vacancy and turnover rates for care workers across the UK regions, differences within regions can be very significant – with some local authorities in London reporting vacancy rates of 30 per cent (Eborall and Griffiths 2008). Housing costs are a key reason for this variation. However, while low geographical mobility has long been recognized as a feature of the UK labour market, its implications in terms of mismatch between labour demand and supply are not entirely clear (Adams et al. 2002; Collier 2005).

As shown in the previous chapter, many social care employers have recruited migrant care workers as a response to the mismatches between demand and supply of domestic workers in terms of expectations, geography or skills. Certain groups of migrants may be prepared to do work which is low-paid or considered low-status, or for which they are overqualified. This may be because they have a ‘temporary mindset’ (Anderson and Ruhs 2008), because even low wages are higher than in their country of origin, because they may be not eligible for benefits, or because they have no or few family commitments. In the next sections we will look in more depth at the specific reasons which shape employers’ decision making and preferences for migrant workers.

5.2 Employers’ reasons for hiring migrant workers: existing knowledge

Research in and outside the UK on the attitudes of employers towards migrant workers provides a useful frame of reference for understanding employers’ claims about why they draw from particular labour pools and why they need migrant workers. It is interesting to summarize some key issues emerging from this research.

Employers are typically aware of the dual frame of reference of migrant workers, i.e. that migrants are willing to accept wages and working conditions that are poor by the standards of their host country because they are higher than those prevailing in the countries of origin (Anderson et al. 2006; Waldinger and Lichter 2003). The perceived differences in reservation wages (that is, the minimum wage that workers are prepared to work for) and expected minimum employment conditions between migrants and locals, and between different groups of migrants, can be expected to have an important impact on employers’ preferences for one pool of labour over another (Anderson and Ruhs 2008).

Existing studies involving interviews with employers often bring out employers’ appreciation for migrants’ superior ‘work ethic’ (Anderson et al. 2006; Dench et al. 2006; Anderson and Ruhs 2008). This proved to be the case also for employers in the UK care sector (Experian 2007).

There are several reasons why certain groups of migrants are perceived to have a 'better work ethic' than local workers, and these may derive from both differences in migrants' frames of reference and personal characteristics. The main one is a greater willingness than local workers to do the job on the employer's terms (Waldinger and Lichter 2003). This may be related, for example, to the less secure employment conditions, an immigration status that bind them to the employer, or the absence or smaller size of family and social networks. Other factors may be the lesser likelihood of trade union membership and the fact that migrant workers are more likely to live-in, thus being available 24/7.

Stereotypes about cultural traits and characteristics may also shape preferences of employers for certain groups of migrant workers. For example, in the care sector some national groups (e.g. Filipinos) may be seen as having a 'more caring ethos' and a greater willingness to help, and are therefore preferred to other workers for certain roles (Moriarty et al. 2008). Interestingly, interviews with migrant workers have suggested that migrant workers may see themselves as having a more caring ethos and a greater willingness to help others (Datta et al. 2006).

While the salience and impacts of these factors may vary across employers, they all represent possible reasons why employers might develop preferences for workers of specific nationalities. In the US context, employers' hierarchical preferences for certain employees were described in terms of 'hiring queues' (Waldinger and Lichter 2003). Interviews with managers of care organizations in the UK (unpublished work by Hussein et al. 2008, cited in Moriarty et al. 2008) suggested similarities with the US research. In the UK, an immigration status which restricts labour market mobility may also incline some employers to a preference for non-EEA workers over EEA nationals.

On the other side of the equation, employers also tend to identify challenges of employing migrant workers. Poor language skills are typically the most important drawback mentioned in the surveys of employers (see e.g. Anderson et al. 2006; Experian 2007; Hussein et al. 2008): this is a key issue to which we return in chapter 6. However, foreign language speakers working in ethnically diverse areas may also possess language skills and knowledge about cultural and religious practices that enable them to work with service users who share a similar background; and employers may be aware of the need to train UK workers caring for clients with different cultural and / or religious background (Moriarty et al. 2008).

As we shall see in the following sections, the findings of our survey of owners and managers of organizations providing care for older people are essentially consistent with the broader picture emerging from past research on employers' preferences.

5.3 Employers' reasons for hiring migrant workers: empirical evidence for the care sector

Employers' experiences of recruiting and employing migrant carers were at the core of our survey of 557 care providers for older people. In this section we review the opinions of our respondents in relation to their ability/inability to recruit UK born carers, the perceived advantages and challenges of hiring and employing migrant workers, and the consequences of employing migrant carers in terms of quality of care and staff relations.

5.3.1 Difficulty in recruiting or employing UK born workers

A high proportion of the participants in our survey – 58 per cent in relation to nurses and just under 50 per cent in relation to carers (figure 5.1) – said that it is difficult for them to find UK born workers. In fact our data show that the demand for migrant workers is clearly related to the difficulty of recruiting UK born nurses and carers. The proportion of those who find it difficult to recruit UK workers is much higher among the organizations employing migrants (72 per cent and 60 per cent respectively for nurses and care workers) than among those relying exclusively on the domestic labour force (28 per cent and 27 per cent).

In-depth interviews confirmed that in many UK regions the demand for nurses and carers to work in the private sector often outstrips supply:

'If you look in any of the local newspapers, there are pages and pages of care assistants, senior care assistants, nursing auxiliary jobs being advertised. The demand far outweighs the supply.' (Manager of a residential care home in the South East)

A number of providers clearly said that by no means, even by recruiting migrant workers, could they fill all their vacancies.

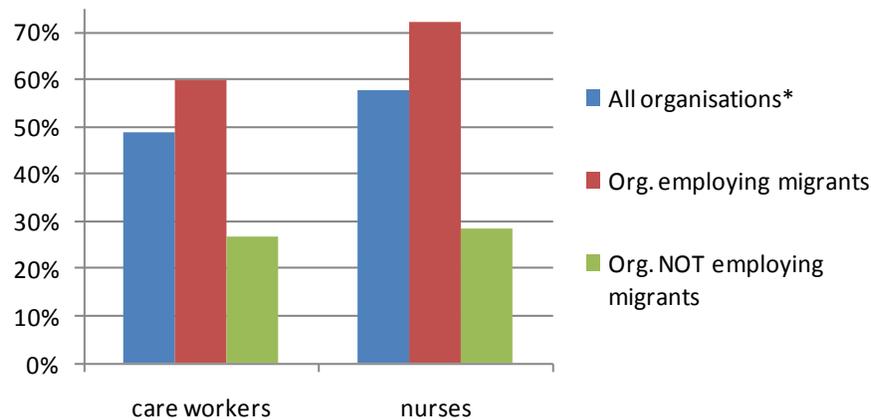
Other providers commented that they get very little response from UK born workers even through local advertising, migrants often being the majority – sometimes the large majority – of applicants:

'We don't specifically go out with the intention of just recruiting migrant workers, it just so happens that we have the majority of them apply to us. So it's not a case that we heavily recruit migrant people.' (Manager of home care agency)

Employers' opinions about the reasons for the shortage of UK born workers are displayed in figure 5.2, ranked by level of agreement with the various statements presented in our questionnaire. Most employers agreed with all the statements, showing that they perceive the difficulty in recruiting/employing the domestic workforce as related to a combination of factors

such as poor working conditions, lack of career opportunities, skills mismatch and poor motivation. The factors eliciting the broadest consent are related to the poor wage levels in the sector: 87 per cent agreed that UK born workers can earn more in other jobs and 74 per cent that they demand higher wages than those paid in social care.

FIGURE 5.1: PROPORTION OF EMPLOYERS WHO FIND IT DIFFICULT TO RECRUIT OR EMPLOY UK BORN CARE WORKERS AND NURSES



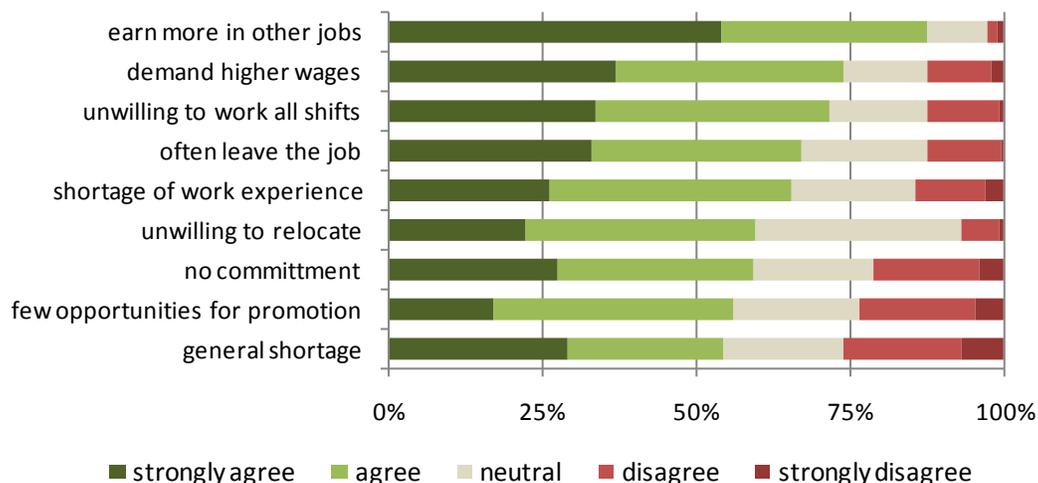
* For nurses, only organizations employing nurses.

Source: COMPAS survey of employers (2008).

The role of low pay levels in pushing local workers out of the sector is also one of the major issues stressed in many in-depth interviews. An example frequently made was that the salary of a care worker was the same as that paid in the local supermarket. In addition, several employers emphasized the impact on the pay structure of the budget constraints under which their organizations were operating because of the high reliance on public funding:

‘If we could pay twice the minimum wage, then we would attract more local staff, and they would be more prepared to work those hours. But our funding is from the Local Council. 80 per cent of our clients are funded totally by the local council. I’ll give you an example. The local council, this year, unilaterally, on the 1st April, put the rates of pay to us, for the clients, up 2 per cent. But our costs have gone up 5.8 per cent. There is no way I can recoup that. And so, the staff are paid at a low level. I’m sure if the local council paid a more reasonable rate, we would be able to pay a more reasonable level of pay and that may well attract local staff to work on a Saturday or Sunday, at the night time.’ (Manager of a residential care home in the South East)

FIGURE 5.2: REASONS WHY EMPLOYERS FIND IT DIFFICULT TO RECRUIT OR EMPLOY UK BORN WORKERS



Source: COMPAS survey of employers (2008).

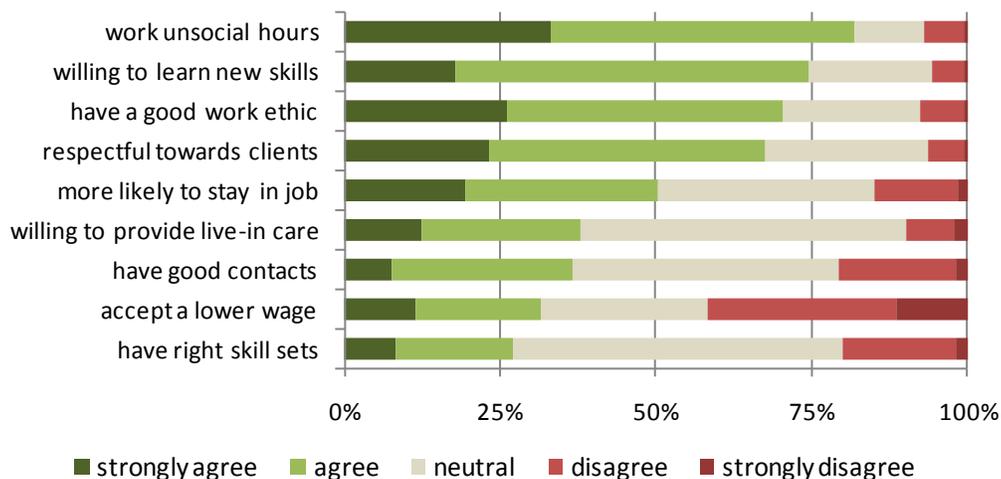
Other major obstacles to recruiting and retaining domestic workers identified by at least two-thirds of surveyed employers are an unwillingness to do shift work (72 per cent), the high probability that they will leave the job (67 per cent), and the lack of the right work experience (66 per cent) (figure 5.2).

5.3.2 Advantages and challenges of employing migrant workers

The unavailability of UK born workers is not the only reason for hiring migrants, as shown by the significant proportion of employers who employ migrants even if they claim that UK born workers are not difficult to find: 44 per cent of those saying they can easily recruit UK born nurses and 52 per cent of those assuming that there are enough British-born care workers to fill their vacancies employ migrant workers anyway.

Employers in the care sector said that employing migrant workers may have a number of advantages for their businesses (figure 5.3). 82 per cent of respondents who employ either migrant nurses or carers agreed that migrants are willing to work all shifts. Many employers participating in a follow-up interview stressed how important this feature is for the characteristics of their services and ascribed the flexibility of migrants' working schedule to the lack of family commitments. A wide consent was also reached around the ideas that migrants are willing to learn new skills (75 per cent), have a good work ethic (71 per cent) and are respectful towards older clients (68 per cent).

FIGURE 5.3: EMPLOYERS' PERCEPTIONS OF THE ADVANTAGES OF EMPLOYING MIGRANT WORKERS



Source: COMPAS survey of employers (2008).

What employers mean by 'work ethic' was one of the issues debated in the in-depth interviews. One employer explained that:

'[migrants] are more punctual. They don't take time off without genuine cause. They're more willing to do extra work if it's available; you know, just generally they're polite and very very personable... and more willing to be open and friendly.' (Manager of a residential care home in the South East)

Other expressions used to define a good work ethic included: hard-working, reliable, available, dedicated, flexible, inclined to buckle down, industrious, respectful. Some interviewees even contrasted the migrants' good work ethic with the lack of commitment of local workers:

'In care you get a lot of English people who basically are from the bottom of the pond who are looking for, you know, easy money or looking to do something with an older person, where they are not really supervised, yeah, they can do as little as possible... we don't really have that problem so much with the migrant workers.' (Manager of a home care agency in the South East)

'[Migrants] are very respectful of the elderly, they're very very interested [...] British workers don't seem to show much interest in their past lives at all. They come to work, they want to do the job and they want to go home.[...] [migrants] want to find out what these people did for a living, where they grew up and that

makes a huge difference in giving self-esteem and value to the elderly.' (Manager of a residential care home in the South East)

However, the picture is not always fully positive. For instance, some employers complained about the unprofessional behaviour of some migrant workers in leaving the job (e.g. giving no notice).

Half of respondents, however, said that migrants are more likely to stay in a job. This perception is seemingly in conflict with the results – based on the reported figures on workers who have left their job in the year preceding the survey – showing that migrant nurses and carers have higher turnover rates than UK born workers. However, it was established in the in-depth interviews that employers' experiences with retention of migrant workers vary significantly by national group (and immigration status): a high propensity to leave the job is usually reported only for East Europeans, while in contrast Filipinos are often praised for their stability within the organization.

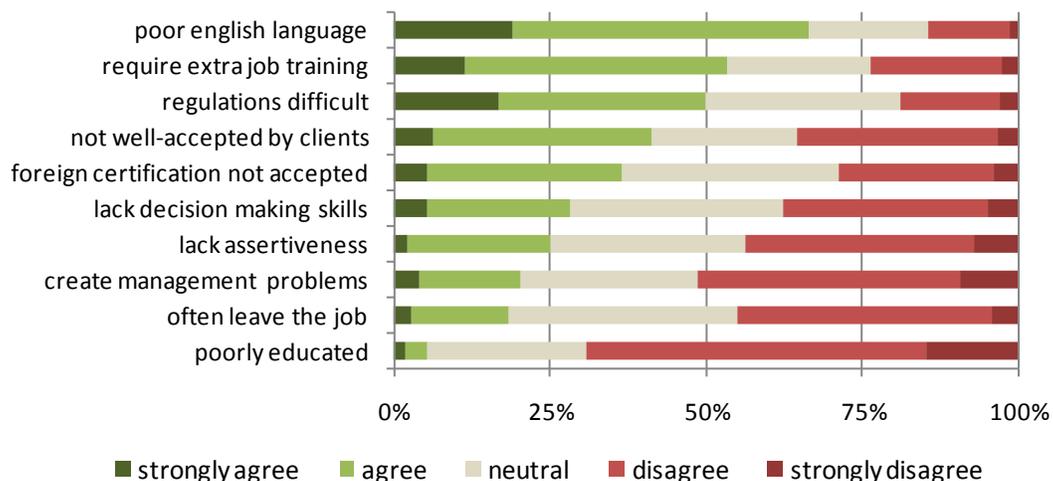
Comparatively fewer respondents were interested in the availability of migrant workers to provide live-in care (38 per cent) or in using their contacts to recruit other migrant workers (37 per cent). The statement that migrants accept lower wages than UK born workers obtained the largest level of disagreement, which is not surprising given the somewhat provocative nature of the argument. Still, nearly one in three employers (31 per cent) agreed on this.

Participants in the survey were also asked to identify possible challenges of recruiting/employing migrant workers (figure 5.4). For most employers (66 per cent) the main disadvantage is their poor language skill.

Language and communication were by far the main barriers mentioned in the follow-up interviews, particularly in relation to older people with poor cognitive abilities or sensory impairments (such as deafness or dementia). It was not only the poor knowledge of English that was perceived as a challenge, but also – sometimes even to a greater extent – accent, form of speech and intonation of the voice:

'There is no intonation in the voice. So if I ask somebody, "Would you mind if you just come and check this with me? Or would you help me?" It's very severe, lumbered speech so it's "you come and check this" or "you do this"... They don't have any intonations whatsoever and we do have to understand that but because I am looking after an older group of clientele and my patients then can interpret that as somebody being quite abrupt really.' (Manager of a residential care home in the North West)

FIGURE 5.4: EMPLOYERS' PERCEPTIONS OF THE CHALLENGES OF EMPLOYING MIGRANT WORKERS



Source: COMPAS survey of employers (2008).

Less frequently the language barriers were referred to as a problem for communication among staff, for understanding of duties or in relation to health and safety procedures.

Other challenges of employing migrant workers faced by a relatively large share of the employers are the need for extra job training (53 per cent) and problems experienced with regulations (50 per cent), including delays in visa processing, restricted opportunities for applying for work permits and fear of penalties for employing migrants not allowed to work. In telephone interviews some employers also expressed frustration that their non-EEA staff could not access NVQ courses to obtain social care qualifications:

'NVQ training is not allowed until the overseas member of staff has been in the country for three years... which is absolutely ridiculous because the person benefiting from the training, at the end of the day, is the resident. So how we do it is that we do it in house, and we do it without the qualification.' (Manager of a residential care home in the South East)

One particularly difficult issue some employers raised (41 percent) is the reluctance of some older clients to be cared for by migrants, an issue that we address in chapter 7. A number of employers reported in the phone interviews that some of their clients were hostile to some or all migrants. In some but not all occasions this was related to language ability or understanding of their needs. Situations such as older people not wanting a migrant carer in their room or verbally abusing them with racial insults were reported. Older people's resentment is reported particularly against African carers.

In many cases employers to whom we spoke reported that once the care was provided by a migrant, the attitudes of the care users became more positive over time, older people feeling more comfortable with their migrant carers when they get to know them:

'We are talking about clients that are between 80 and 100 years old. And to have somebody who has an accent and has a colour to their skin is new to them, and until they know the person a number of our residents are apprehensive and on occasion have been rude and out of line. But once they get to know the staff member as a person rather than that they are from a foreign country then that problem seems to disappear. That issue is the same with the local staff. Initially when the overseas girls came here some of the staff were reluctant to work with them to the same extent as they would with one of their own. But since they have become aware of [them] and got to know the girls personally those issues, to a large extent, have disappeared.' (Manager of a residential care home in the South East)

In some cases, employers associated the negative attitudes with language, or with lack of knowledge of customs or particular care needs. In other instances, employers said that while reasons for the client's attitude were not always explicit, the hostility was overt:

'It's not a problem with the skills or the language of the migrant worker, it's a fact that if they appear at the door the door will be shut in their face.' (Manager of a home care agency in the South East)

'They're quite discriminating really but we've got to take account of the age group, because a lot completely refuse, they don't want them in the room and ask them to go away and they are quite rude to them.' (Manager of a residential care home in the North West)

Several managers of care organizations stressed how difficult it was for them to deal with their patients' resentment, especially when racist language was being used by elderly people with high levels of dementia. Many of them felt that they face a tension between protecting their staff and showing respect towards older people's views in relation to the choice of their carer. One agency reported:

'When we do an assessment for a new client package and they say to us I don't want a black person or I don't want an Eastern European person then we'll say well we can't provide you with care. We don't take on clients who have that attitude.' (Manager of a home care agency)

Others emphasized the importance of meeting their clients' needs, making reference to their competing obligations:

'We have obviously got to keep our service users happy, that's number one in business, keep your customer happy. And obviously we've got to look at the law as well, with the equal opportunities. But we always try to match the carer to our service users... if they are very adamant about a particular carer, whether it's just the look about them, the colour or they don't like the personality, we do try and fit the carer with the service user.' (Manager of a home care agency in the South West)

A frequent response was to remove the carer and replace them with someone more acceptable to the client, not necessarily a UK born carer. One provider of domiciliary care (for around 300 clients), who emphasized that their clients were often frail, elderly people, some of them with dementia, said they found it necessary to replace a carer in these circumstances around 'two to three times each week'. In some cases

'we then put coded notes on our system for our internal staff to know never to send a coloured person again.' (Manager of a home care agency in the South East)

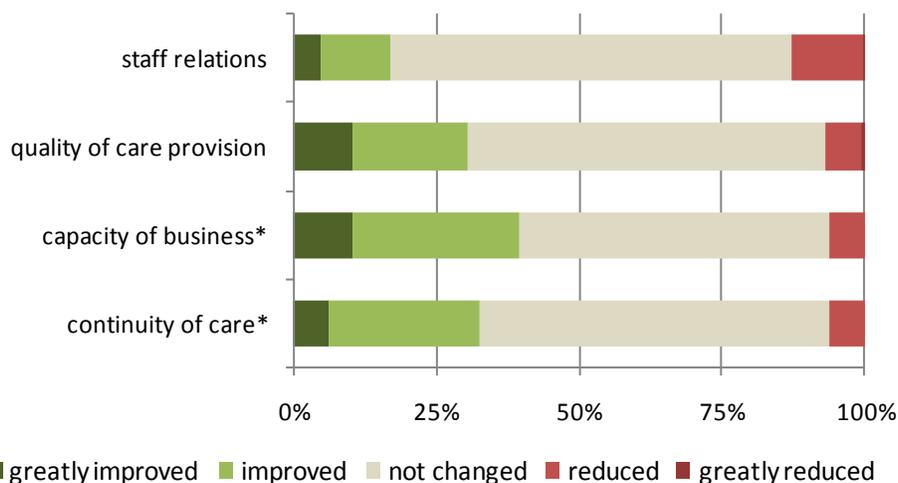
Some employers also reported problems with older people's relatives complaining that the proportion of migrant staff was too high, in one incident saying that they would remove their relative from the care home 'if this place becomes any more multicultural'. While some employers mentioned seminars and circulars covering these issues, others reported that they had received no guidance on how to deal with these situations.

The other possible challenges in relation to which employers were asked their opinion in the on-line survey achieved a relatively low consent. Only one in five employers agreed that migrants create management problems or often leave the job. The large majority of respondents (69 per cent) disagreed that migrants are 'poorly educated', only 5 per cent supporting this statement.

5.3.3 Consequences of employing migrant carers in quality of care and staff relations

The experiences of employers with foreign born workers were also explored in the survey by asking them what impact the employment of migrant staff had on the quality of care and on staff relations within their organizations. In terms of staff relations, the vast majority of respondents said that the situation had not changed since they started to employ migrant workers (figure 5.5).

FIGURE 5.5: EMPLOYERS' PERCEPTIONS OF THE IMPACT OF EMPLOYING MIGRANT WORKERS



*only home care agencies

Source: COMPAS survey of employers (2008).

Also in the in-depth interviews a positive or negative impact on staff relations was only occasionally reported – e.g. referring to the benefits of a culturally diverse work environment or to tensions between the UK born and migrant staff.

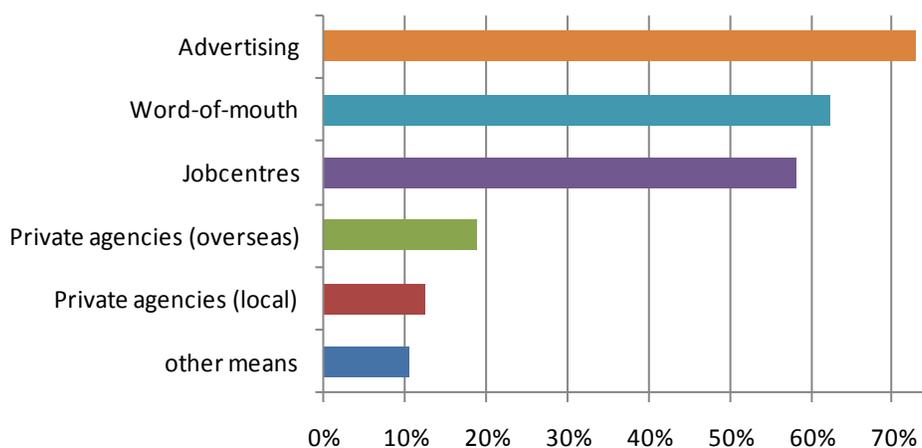
As for the quality of care, although over 60 per cent of employers agreed that employing migrant workers has not changed the quality of care in their organizations, a significant 31 per cent considered the quality of care to have improved, while only 7 per cent said that it has worsened. In particular, a significant proportion of home care providers (40 per cent) said that the capacity of their businesses has increased.

5.4 Methods of recruitment and use of agencies

Organizations in the care sector recruit migrants in various ways, mostly within the domestic labour market. Advertising in local newspapers (71 per cent), asking their workers whether they know other people suitable for the job (63 per cent) and using Jobcentres (58 per cent) are the main methods used by employers in the home care sector (figure 5.6).⁶¹ A much lower proportion turn to private agencies (either recruiting locally or bringing in people from abroad) to fill vacancies: only 19 per cent of home care providers use agencies recruiting overseas.

⁶¹ In the mail survey the question on the methods of recruitment was introduced only for home care providers.

FIGURE 5.6: METHODS OF RECRUITMENT OF MIGRANT CARE WORKERS IN THE HOME CARE SECTOR



Source: COMPAS survey of employers (2008).

The in-depth interviews with both residential and home care providers substantially supported this picture. One employer explained the way they recruit their staff:

'Our normal recruitment process is we go through the Jobcentre, here in the UK. We put adverts into the local papers. Following that, if the response is poor... I am actually in the middle of doing a recruitment drive at the moment, and the response has been poor, I then start to look at whether I need to go abroad again. So I always give the opportunity to home grown applicants, but obviously needless to say, if they don't meet the criteria, then, you know, that's when we move abroad. So when we start to recruit abroad, I tend to use an agency.'
(Manager of a recruitment agency and domiciliary care agency in London)

In the phone interviews, more than one employer reported that sometimes they do not even need to advertise their vacancies because migrant nurses and carers – as opposed to UK born workers – are often very enterprising and get in contact with the organization or send CVs to see whether there are available positions.

Overall – i.e. including participants in the survey from both the residential care and home care sectors – the proportion of employers using agencies recruiting either domestically or overseas is just above 30 per cent. Much lower (only 5 per cent) is the share of organizations using workers contracted out by an employment business – i.e. workers not directly employed by the care provider but casually contracted to deal with staff shortages. These figures show that for most employers outsourcing staff recruitment to specialized companies remains a secondary

choice.⁶² One employer explained how their organization started to use agencies as a result of the increasing difficulty of recruiting locally:

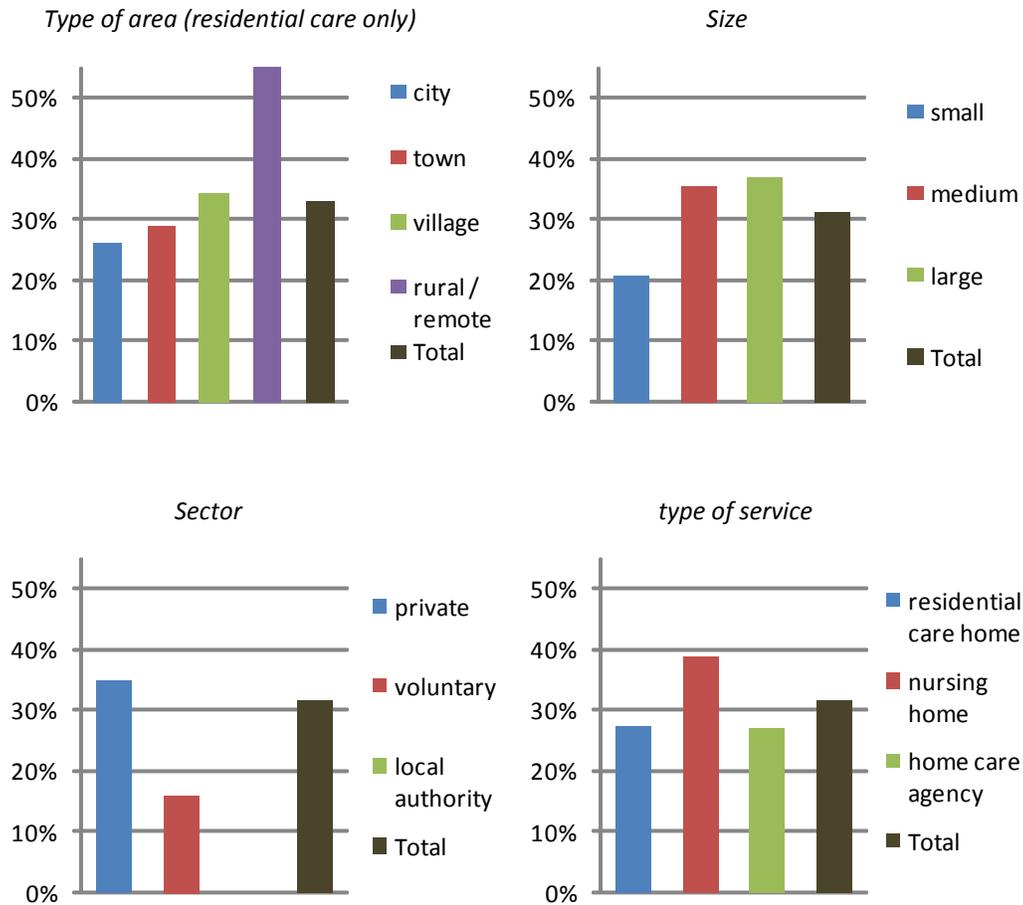
'If there is somebody that a member of staff knows and is looking for employment, then we will try them first. Ten years ago, then probably 50 per cent of our staffing needs were met in that way. We then apply to the local newspapers and put advertisements in those and again, up until probably ten years ago, we were fully satisfied that we could always fill vacancies. Over the last ten or twelve years, it has become more and more difficult to fill the vacancies and so, about three years ago, you'd get the odd flyer through the door from agencies, to say that you can get staff, and that's the route we took. We made contact with an agency and that agency initially furnished us with two Filipino girls and that seemed to work well and that's the route we continued on. In fact we stayed with the same agency right the way through.' (Manager of a home care agency, London)

A breakdown of the survey data by type, location, sector and size of the organization sheds further light on the characteristics of the businesses which turn to recruitment agencies (figure 5.7). For instance, among residential care providers based in rural or remote areas the share of those outsourcing recruitment of migrant workers is significantly higher (55 per cent). This is no surprise, given that recruitment may be much more difficult in areas with a scattered population and workforce – in fact, the larger the urban area, the smaller the share of organizations using recruitment agencies.

The data also suggest that large organizations are more likely than small organizations to outsource their recruitment; that this is also more often the case among nursing homes than among other providers employing only care workers, arguably because they need to recruit staff with different skills; and that organizations in the voluntary sector are less likely to use recruitment agencies (only 16 per cent) than private sector providers.

⁶² However, for some employers recruitment agencies are the main method of recruitment. These employers indicated some potential downsides of the other recruitment strategies – e.g. the high cost of advertising and the very poor response from local workers, many people coming from Jobcentres only to fulfil their jobseeking tasks and stay on benefits.

FIGURE 5.7: PROPORTION OF ORGANIZATIONS USING RECRUITMENT AGENCIES TO HIRE MIGRANT WORKERS, BY TYPE OF AREA, SIZE OF ORGANIZATION, SECTOR AND TYPE OF SERVICE

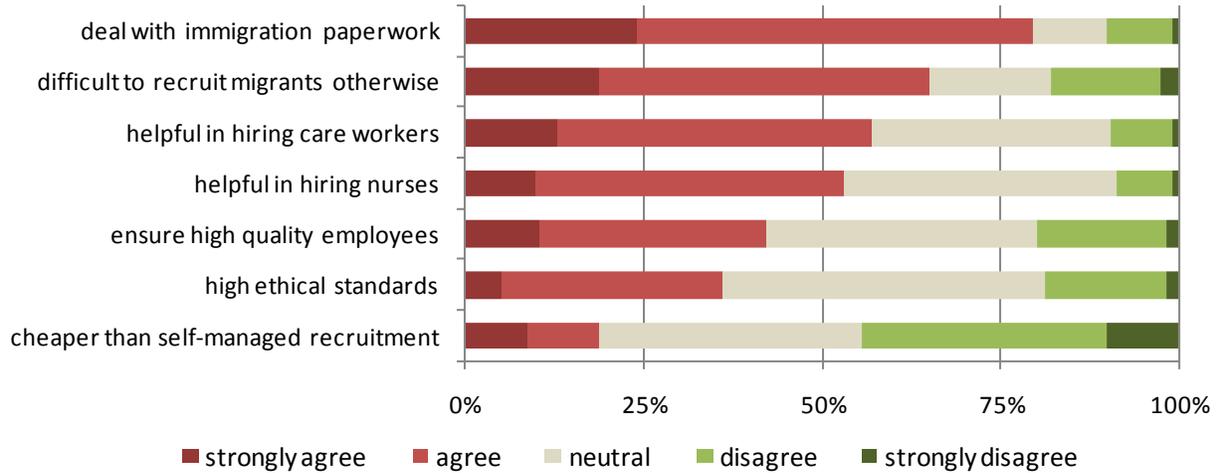


Source: COMPAS survey of employers (2008).

Employers' level of agreement (or disagreement) with statements concerning the reasons why they were using recruitment agencies (figure 5.8) confirmed that this is often the only means to recruit migrant workers (for 65 per cent of them). However, the advantage of recruitment agencies which elicited the broadest consensus is that they take care of immigration paperwork (79 per cent). This is related to the abovementioned numerous problems that employers experience in their contacts with the immigration authorities when they hire migrant workers.

Our results show that recruitment agencies are used in equal measure to hire migrant care workers and migrant nurses. In the in-depth interviews in relation to recruitment abroad employers mentioned agencies operating in a number of countries, including Poland, Slovakia, India, the Philippines and South Africa.

FIGURE 5.8: REASONS FOR USING RECRUITMENT AGENCIES TO HIRE MIGRANT WORKERS



Source: COMPAS survey of employers (2008).

Less than half of participants in the survey (42 per cent) agreed that agencies provide high-quality staff – although some interviewees perceived the screening of relevant work experience as an advantage, especially for professionally qualified staff. The main perceived downside of outsourcing recruitment to a specialized agency is the cost. Other issues such as the high fees charged to migrants to get them to the UK or lack of transparency of the information provided to them were occasionally reported in the in-depth interviews. One employer also hinted at possible illegal practices:

‘We did get caught with an agency a few years ago that weren’t operating legally unfortunately. But, fortunately for us, it wasn’t with our carers... It’s another hurdle we have had to overcome, to try and find an agency who we could trust and put our faith into!’ (Manager of a residential care home in the South East)

A couple of employers also reported that it was taking longer and becoming more difficult for agencies recruiting abroad to get senior care workers to the UK and sort out the immigration paperwork, and pointed to possible challenges relating to legal channels:

‘That process would sometimes take two months, but sometimes take five or six months. And we never knew exactly when the staff were going to turn up. It all seemed a little hit and miss. The agency always said this was beyond their control, that it was the Home Office being malicious in trying to slow down people coming into the country. ... I have asked the agency over the last, probably

six months to nine months, can we recruit two more staff from the Philippines, or whatever you suggest, and we have been unable, and the agency have been unable to recruit any new staff for us.' (Manager of a residential care home in the South East)

5.5 Influence of immigration status on the recruitment and retention of migrant workers

As discussed in section 5.3, the experience of employing migrant workers reported by employers suggests that, while the main reason for recruiting migrants is usually the perception that there are not enough UK born workers available to take up care jobs at the conditions prevailing in the labour market, employers can also develop a preference for migrant workers because of their higher flexibility, 'work ethic' or care ethos.

Although many migrants may actually be more motivated, keen to work and culturally inclined to caring for older people, it may be the case that their attitude and preferences are shaped more by constraining factors than by motivation and inclination. What employers perceive as 'willingness' to work long hours or accept demanding working conditions is often the result of a lack of alternatives. Migrant workers may actually need to accept unfavourable working conditions because they do not have a strong family or social network to rely upon; because they have a large family in the country of origin living on their support; or because their immigration status affects their opportunity to change employer and their eligibility for public benefits.

This section analyses the migration routes and pathways into the care labour market of migrant care workers interviewed for this study. As we shall see below, our findings suggest that immigration status of migrant care workers influences both their recruitment and their retention within the care sector. In particular, restrictions and entitlements attached to immigration status shaped reasons for entering care work of our migrant interviewees; their 'willingness' to stay in a job and accept particular terms and conditions; and their ability to 'move on' to other jobs, including advancement to higher-level health and social care positions.

To understand this argument the reader should bear in mind that migrant carers interviewed in this research were predominantly recent arrivals (entering the country between 1998 and 2007)⁶³ and most of them – excluding ten A8 care workers who migrated to the UK after the 2004 EU enlargement – were non EU nationals subject to immigration controls when they migrated to the UK. The data and use of the term 'migrant care workers' in this section, with reference to these respondents' experiences, are therefore distinct from the data on foreign

⁶³ Except for three respondents who had arrived between 1990 and 1997 (see appendix 3).

born care workers referred to previously (which includes recent and non-recent arrivals in the UK and both foreign nationals and British citizens).

Five out of 56 migrants interviewed for this study were at the time of the interview, or had in the past been, employed without permission to work in the UK – while waiting for their asylum application to be processed or overstaying student or tourist visas. Migrant carers employed irregularly may be particularly vulnerable to exploitation (Anderson and Rogaly 2005). Although neither our sample nor other data enable us to estimate the extent of irregular employment in the care sector, previous qualitative studies also identified the presence of irregular labour practices in the employment of care workers (Anderson and Rogaly 2005; McGregor 2007).

5.5.1 Countries of origin and processes of migration to the UK

The main countries of origin of respondents (based on their nationality and country of birth) were Zimbabwe, the Philippines, India and East European countries (including the EU member states the Czech Republic, Hungary, Lithuania, Poland and Slovakia).⁶⁴ These countries correspond with the principal countries of origin of the migrant social care workforce overall, based on LFS data (see chapter 4). There was a diversity of immigration status among respondents, which matched the diversity of status of the migrant social care workforce among the employers surveyed (as referred to above), including work permit holders, students, refugees and EU nationals (see appendix 3, section A3.3, for details on the immigration status of respondents). These different channels of entry to the UK were associated with migrant workers' country of origin (e.g. those entering on work permits were mainly from the Philippines).

Respondents' recruitment into the UK care sector included both international and local recruitment processes. Some migrant workers (work permit holders and EU nationals) had found work in the UK care sector *prior to* migration through international recruitment agencies. Others (e.g. students and refugees) had found work in the care sector through local recruitment processes *after* coming to the UK, including by word of mouth through informal networks (friends already working in care), through local employment agencies or by responding directly to job advertisements.

Zimbabwe and other African countries of origin

The migration of respondents from Zimbabwe to the UK was predominantly related to the deteriorating political and economic circumstances in Zimbabwe from the early 2000s onwards.

⁶⁴ One respondent was from Albania.

Zimbabwean care workers (15 respondents) had entered the UK through the following channels: on tourist visas to visit family members living or studying in the UK, subsequently staying on given the circumstances in Zimbabwe (either applying for asylum, a work permit or a student visa, or overstaying their tourist visa); as asylum seekers or spouses of refugees; or on student visas. Other respondents from African countries of origin (Gambia, Kenya and South Africa) had come to the UK on student visas or on domestic worker visas.

Zimbabwean respondents generally did not have a background in health and social care for older people (except one respondent who had been studying to be a nurse), although some referred to experience of caring for older family members in Zimbabwe. Prior to coming to the UK, some had been employed in administrative work or posts in government or teaching, while others had been students. After arrival in the UK, they had found jobs in the care sector either through informal networks or local employment agencies, or by responding to local job advertisements directly.

Philippines and other Asian countries of origin

Most care workers from the Philippines (13 respondents) had come to the UK on social care work permits (as senior care workers) or on domestic worker visas. The former had been working in health and social care related work in the Philippines or other Asian countries (Singapore) prior to coming to the UK and had found work in the UK care sector through recruitment agencies operating in the Philippines. Their work permits were arranged through these agencies with their employers (care homes and care home groups) before they migrated to the UK. Those entering on domestic worker visas had been employed by individuals or families, either in their country of origin or in other countries (Cyprus and Kuwait), in domestic work or childcare in private households. They had migrated to the UK with their employers, who were responsible for applying for their visas. Domestic workers had entered care work for older people in the UK while looking for other local jobs in private households, through informal networks or through agencies for domestic staff. Most care workers from India (seven respondents) had also come to the UK on domestic worker visas, as had those from Sri Lanka (two respondents). One respondent from China had entered on a student visa, having subsequently obtained a work permit.

East European countries of origin

Care workers from East European countries of origin within the EU (13 respondents) were from Poland, Slovakia, Lithuania, the Czech Republic and Hungary. Most had come to the UK after the EU enlargement in 2004 as EU nationals; three had arrived prior to enlargement on a student, tourist or au pair visa, and subsequently stayed on as EU nationals after 2004.

Some respondents from Eastern Europe had backgrounds in nursing or experience of other care-related work. Their motivations for coming to the UK were partly economic, wages in nursing being lower in Poland and other East European countries, but also included a desire to travel. They had found work in care homes for older people in the UK while working in Poland and/or other East European countries, either through their local public employment service, through a recruitment agency, or through a UK employer directly advertising and recruiting in their country of origin. Other East European respondents did not have a care-related background and had been students (in non-care-related areas) before coming to the UK; their motivations included the desire to travel and experience living in another country, and economic reasons, including to contribute to the cost of their studies. They had found work in care for older people after coming to the UK – through local job advertisements, through registering with local employment agencies, or through friends already working in the UK care sector – primarily because these jobs were easy to find.

5.5.2 Entry to care work

Restrictions attached to immigration status, or other difficulties with entering the UK labour market, shaped some migrant workers' reasons for working in the care sector.

Among Zimbabwean respondents, reasons for entering social care work for older people were partly shaped by difficulties in finding other types of work (despite the diversity of employment and educational backgrounds of these respondents). Care work was among a limited range of low-paid jobs respondents had been able to access (some had also done cleaning, factory or catering work in the UK before entering the care sector).⁶⁵ For some Zimbabwean respondents, the decision to enter care work was defined not as a 'choice' but as a 'need', being a source of employment and income. Indeed, some referred to social care as being the main source of employment for Zimbabweans in the UK.

'I generally looked for work in health and social care because it was kind of routine for most Zimbabweans. Health and social care is the main industry, so the only information on jobs I had got from people was health and social care and I ended up getting into it.' (Male Zimbabwean care worker, home care)

'It was very hard... I didn't like it but I had no choice. I needed income to pay the rent and fees you know. So you just have to do it.' (Female Zimbabwean care worker)

⁶⁵ Care work was also perceived by some as providing opportunities for doing more 'interesting' work in which employers provided training opportunities, in comparison with other low-paid jobs they had experienced, while some felt most suited to care work in terms of their personal skills.

Zimbabwean care workers' reasons for entering the care sector were also partly shaped by the restrictions imposed by their immigration status or 'irregularity' of status. This concerned the experiences of respondents who had been asylum seekers or had overstayed student or tourist visas, and were not entitled to work in the UK. They indicated that their access to work was limited to the care sector, where demand for care workers was such that employers were willing to overlook restrictions on their right to work or the irregularity of their status.

Zena, who came to the UK from Zimbabwe as an asylum seeker, referred to her experiences of working as a care assistant in a residential home during the period in which her asylum claim was being processed and she was not entitled to work. She related her 'willingness' to work in the care sector, and to accept work that paid the minimum wage and involved long hours, to her lack of 'choice', given her status and need to find work.

'I had very little option to be honest of what I could do. I either had to butter my bread or just stay at home and be looked after by my friend who I was staying with. I knew that I had no way of getting into the [type of work respondent did before coming to the UK], which was quite difficult... First when I started working, I have to be honest it was very informal because I didn't have any papers. They [the residential home] really desperately needed people. And for that time, for two months I worked there and I didn't have any papers. They used my passport. That was the only thing and my friend was their reference. And I worked for two months and they trained me within because they said, "We need carers as much as possible and we will wait if you're saying your [asylum] application has gone." Because I showed them the papers, that it had gone to the Home Office. And the salary was basically about £4 something an hour.⁶⁶ And you would work about 12 hours a day. So I had no option and it's not easy. I was alone here and my family was still at home.' (Female Zimbabwean care worker, nursing home)

Immigration status also shaped migrants' entry into particular types of care work. Access to the care sector for respondents from the Philippines, India and Sri Lanka, who came to the UK on domestic worker visas, was limited to work in private households because of the terms of their status as domestic workers. Their immigration status was therefore associated with their positioning within particular types of care work and employment relationships – predominantly live-in care work in private households where they were employed directly by the older people for whom they cared or by family members of the care user.

⁶⁶ The minimum wage was £4.10 from October 2001 to September 2002, the period when the respondent arrived in the UK and first started working in a care home.

5.5.3 Staying in a job

Immigration status was also associated with the (im)mobility of migrant workers within the care sector by shaping the extent to which they were 'willing' to stay in a job and accept particular terms and conditions.

The dependence of work permit holders on their employers (care homes or care groups) for their work permits limited the ability or willingness of some to change jobs. Filipino workers on work permits as senior care workers contrasted their position to that of British and other EU care workers who could more easily change jobs if they wanted, given the rights accorded to British/EU nationals.

'If you have a work permit, you can only work here. Unlike the EU workers, they don't need a work permit, they can go easily from one place to another employer. They don't care because they can get another job.' (Male Filipino senior care worker, residential home)

The status of work permit holders also shaped their willingness to accept unsatisfactory terms and conditions, such as low wages or the same rate of pay for working overtime/bank holidays. Similarly, these respondents contrasted their position to that of British and other EU workers in terms of their differential ability to negotiate better terms and conditions with their employers because of their dependence on their employers for their work permits.

'If you are British here, although we know as well the law, they can complain, but us, you know, who are from other country, we cannot, you know, express our feelings because we need this work, we have to work. Unlike the British people, the British who work here, they just try it here and after one month they're gone. After two months, they run away, they look for another job.' (Male Filipino senior care worker, residential home)

Although some work permit holders were aware that they were, in principle, entitled to change employer,⁶⁷ they emphasized their fear of being unable to renew their work permit or to apply for further leave to remain in the UK in the future should they change jobs.

'I'm a good boy. They said that I can move to another employer... But, you know, I'm stuck, even if I want to move. I said to myself, if I move to another employer that might affect my status after four years, to apply for leave to remain or for

⁶⁷ The new employer of a work permit holder is required to obtain permission from the UKBA regarding the care worker's change of employment.

residency or even citizenship.⁶⁸ So, I just stick with the employer.' (Filipino senior care worker, nursing home)

The obligation of work permit holders to their employer was in some cases reinforced by employers through the employment contract. Some Filipino workers said that they continued to work for the care home where they were employed because, according to their contract, they were required to work for that employer for the duration of their work permit. They felt that leaving their job before the end of their contract would be considered unfavourably by the immigration authorities and/or potential future employers, and might therefore jeopardize the renewal of their work permit or application for further leave to remain in the UK.

This fear and insecurity surrounding immigration status were compounded by recent changes made by the UK government to the regulation of work permits for senior care workers, involving greater restrictions on the issuing and renewal of these work permits (as discussed in chapter 3).

Sam came to the UK from the Philippines in 2005 on a work permit as a senior care worker to work in a residential home in a rural part of England. He had previously worked as a psychiatric nurse in Singapore but decided to come to the UK to work as a senior care assistant because it offered better wages, with a view to supporting his family in the Philippines. After about one year in the UK, Sam decided to leave his job to take up a post in another care home in a city where he had Filipino friends. Although he liked working in care for older people, he felt that his level of experience was not reflected in the wages he received in his current position as a senior care assistant, indicating there was little difference between his wages and those of care assistants with no health and social care experience. He was, however, reluctant to change jobs again for fear of losing his work permit, given the increasing restrictions on the issuing of work permits for senior care workers.

'I don't want, you know, to sacrifice the permit, to try that, because the Home Office is getting stricter and stricter today... So, of course I don't want to lose my job. I don't want to.'

By limiting the mobility of migrant workers within the UK care sector and wider labour market, the status of work permit holders therefore served to provide retainable care workers for residential and nursing homes. Likewise, it served to provide a pool of migrant workers who had higher-level qualifications or experience in health and social care (including those with nursing backgrounds) for senior care worker positions. As indicated by the above respondent

⁶⁸ A work permit holder can apply for permanent residency (indefinite leave to remain) after five years in the UK.

and others, there appeared to be relatively little difference between their wages and those of colleagues employed as care assistants with no related qualifications or experience. Indeed, some respondents were working as care assistants irrespective of their immigration status as senior care workers.

The immigration status of work permit holders was also associated with the *involuntary* mobility of some respondents within or out of the care sector in the UK. Some Filipino workers whose work permits were due for renewal said that they had to find another care-related job as a result of changes to the criteria for issuing work permits. They would have preferred to stay with their existing employers (despite being dissatisfied with some of the terms and conditions of their jobs), but their employers were unwilling or unable to increase their wages to meet the new criteria for work permit renewals. One respondent from the Philippines had been forced to leave his job as his employer (a large care group) had given no confirmation as to whether it would offer him a higher wage in order to comply with new wage-related criteria for renewing his work permit. He had recently found a new job in a care home on the Isle of Man where the UK government's work permit regulations did not apply. Thus his mobility within the UK care sector was directly related to changes in the immigration system.

Irregularity of status, with regard to respondents who had overstayed student or tourist visas, or asylum seekers not entitled to work, also shaped the willingness of these respondents to stay in care jobs in spite of poor terms and conditions, and indeed in spite of experiences of exploitation, such as employers withholding part of their wages.

Daya came to the UK from Zimbabwe as a student at a time when the political circumstances in Zimbabwe were worsening. She started working as a care assistant in a residential home while studying for an administrative qualification, but could not afford to continue the programme because of the fees charged to international students. She continued working in the residential home, having overstayed her student visa. Daya referred to the ability of her employer to take advantage of her status by not paying her full wages, and her lack of ability to complain or change jobs because of her status, which she related to the experiences of other Zimbabweans in the UK.

'It's the immigration status of people that determines what they are able to do and what they're not able to do... maybe they've got student visas, maybe they've just got visitor's visa, or even their visas have expired... I think that's where most of the abuse of staff comes in. Because once your manager knows that you're an illegal immigrant, they know they can do anything. And you can't do anything back. So most of the times, we'll get maybe short paid and we don't say anything, it's because of that. They know that if I go there and complain she [the manager] might just find out.'

5.5.4 Changing jobs and advancement in the care sector

EU nationals, who have the right to work in the UK, found it easier than other migrant workers to 'move on' to other jobs in the care sector. This mobility concerned East European workers' past employment transitions within the care sector in the UK and their intended transitions in the future.

Anya, a care assistant from Poland, who was at the time of interview working for a home care agency, had first come to the UK on a student visa, subsequently returning to Poland and re-entering the UK as an EU national. As a student in the UK, she had worked as a live-in carer employed directly by the older woman for whom she cared. She indicated how the restrictions on the number of hours she could work as a student had limited the type of (part-time) jobs she could access. On her subsequent return to the UK as an EU national, Anya found work with a home care agency but was currently in the process of looking for another care-related job as she was dissatisfied with the insecurity of the variable and sometimes limited hours of work through this agency. She felt that her ability to seek full-time work within the care sector and wider labour market as an EU national had improved her prospects for seeking better terms and conditions of work.

'I think the situation has changed now because we have a right to a full-time job. That's why we can demand more. We can expect more. But in the past, any job was accepted.'

Other care workers from Eastern Europe who were dissatisfied with some of the terms and conditions of their work (such as the low wages, lack of higher rates of pay for weekend/bank holiday shifts, or the timing of work shifts) likewise referred to their ability and intention to 'move on' in the future by seeking other care-related jobs. A care assistant from Lithuania had come to the UK to work in order to contribute to the cost of her university education in law in Lithuania. While she was initially 'willing' to accept less favourable terms and conditions in order to get 'any job' as quickly as possible, she emphasized her intention to leave the residential home where she was employed to find another job within the care sector with better conditions.

'When I was agreeing to my contract, I was desperate for a job and I was agreeing to everything, to any shift, any hour, the minimum of pay. I was happy because, you know, you see this as a start. Of course now I'm thinking of better conditions... shift and the pay, like have the weekends off.' (Female Lithuanian care worker, residential home)

Although East European care workers were not limited by their immigration status in deciding whether or not to change jobs, some respondents referred to ways in which their employers had attempted to restrict their ability to 'move on' to other jobs. Ways of attempting to retain EU nationals included withholding employees' wages. One respondent from Slovakia described how the care home where she was employed had deducted a 'deposit' of £400 from her salary, her contract stating that the money would be returned with a 'bonus' of an additional £200 after three years of employment with the company. The care home had subsequently been taken over by a large care group and the care worker was uncertain whether or not these wages would be returned.

Other workers referred to employers attempting to restrict the advancement of EU nationals in the care sector from lower-level jobs as care assistants/senior care workers to higher-level positions as nurses.

Mariana had previously worked as a nurse in a hospital in Poland for ten years before coming to the UK, having found a job through a recruitment agency in Poland to work as a senior care assistant in a nursing home. Her spoken English was limited when she first arrived in the UK, but after one year she registered as a nurse with a view to moving back into nursing. When she asked her manager if she could take up a nursing position in the nursing home, her manager argued that her experience was not sufficient and that she needed to continue to work as a senior care assistant first to develop her experience. Mariana was paid little more than the minimum wage (£5.40)⁶⁹ by her employer in this position, which she indicated was the same rate as a care assistant but with greater responsibilities. After she applied for a nursing post at an NHS hospital, her manager tried to dissuade her from leaving by telling her she would be incapable of doing the prospective job.

'The manager called me for a meeting to her office and she asked me a few questions. For instance, "Do you think you can manage the job?" and "Who finds this job for you?"... And she said, "I don't know what you did in Poland but I'm sure you cannot manage this job and what you did in Poland is not even like decent." She said, "Be careful, because one day I might come to the hospital as a patient and they will observe you and if you make mistake, I will tell them about you." It was so nasty and I didn't know what to say actually, but she was still my employer and I couldn't be rude.'

⁶⁹ The minimum wage was £5.35 from October 2006 to September 2007 when the respondent was employed by the respective care home.

Mariana was offered the nursing post at the hospital and, at the time of interview, had been working there for three months on an hourly rate of pay that was nearly double her previous wage.

Restrictions on the advancement of other migrant care workers to higher-level positions were also shaped by the terms of their access to work in the health and social care sectors in the UK. As indicated previously, Filipino care workers who had come to the UK on work permits as senior care workers generally had several years' experience working in hospitals in the Philippines or Singapore as nurses, physiotherapists or healthcare assistants. The closing of other types of work permits, e.g. for nurses, had limited their ability to apply for other types of health and social care related jobs before coming to the UK, and to advance to other types of jobs while working within the UK. Although some Filipino respondents felt that they were overqualified for the posts in which they were employed, working as a senior care worker was nevertheless perceived as an opportunity for earning better wages, relative to earnings in higher-skilled posts in countries of origin.

'Basically everybody is here to survive. And everybody is here basically because of the financial benefit that we can gain from here rather than in other countries because the compensation that we receive here is a lot more – better than what we're receiving in Singapore.' (Female Filipino senior care worker, private nursing home)

5.6 Conclusion

Employers' views presented in this chapter suggest that for many organizations the difficulty of finding UK born workers is the main reason for recruiting migrant carers. Nearly half of the surveyed employers consider it difficult to recruit UK born care workers, and four out of five organizations facing such difficulty employ migrants. Employers perceive the unattractiveness of care jobs for the UK born workforce as especially related to the low wages and poor employment conditions in the care sector – e.g. working nights and shifts.

Interestingly, the perception of a shortage of UK born workers is even more widespread among employers who need to recruit nurses, three-fifths of whom cannot fill their vacancies with UK born staff. This shortage of nurses in nursing homes caring for older people contrasts with the government's confidence that the nursing workforce in the healthcare sector can rely on domestic training alone, an approach which underlies the restrictions introduced on the work permits issued to migrant nurses.

Employers' recruitment practices essentially reflect a preference for local over international recruitment. Nine out of ten home care organizations endeavour to recruit on the local labour market – relying on informal networks of their workers, advertising the job locally or notifying the vacancy to Jobcentres – while only one in ten rely exclusively on recruitment agencies bringing in migrants from abroad. Residential care providers too see recruitment agencies recruiting either locally or internationally as a second choice if the vacancies cannot be filled directly. This comparative reluctance to use agencies is attributable mainly to the costs involved. A slightly higher propensity to use recruitment agencies is found among nursing homes, large providers and organizations based in rural areas. It is important to stress that when employers advertise their vacancies locally they experience a higher response from migrants than from UK born workers. This is the case also for unsolicited applications received by employers.

While the main reason for recruiting migrants is usually the perception that there are not enough UK born workers available to take up care jobs at the conditions prevailing in the labour market, employers can also develop a preference for migrant workers because of their greater flexibility or care ethos. A significant proportion of employers participating in our survey agreed that migrants have a good work ethic, are more respectful towards older clients and are willing to learn new skills. Among those who appreciated some change in the quality of care provided by their organizations, four out of five considered the quality of care to have been improved by employing migrant workers.

However, employers also identify some challenges of employing migrants, the principal of which is their English language proficiency: this will be illustrated in more detail in the next chapter. Over half of respondents also agreed that migrants require extra job training. Our evidence suggests that current immigration regulations are also a barrier for employers recruiting migrant workers, about half of whom face problems. These include limited opportunities for applying for or renewing work permits for senior care workers, delays in visa processing, time-consuming paperwork, uncertainty about criteria for applications and the fear of penalties for employing migrant workers irregularly. Attitudes of some older people and their relatives towards migrant carers are a further challenge: this finding is borne out in the experiences of migrants, explored in chapter 7.

Migrants' 'willingness' to accept working conditions that are unattractive to UK born workers may be the result of constraints rather than a genuine willingness. In particular, our interviews with migrant workers showed that restrictions attached to immigration status shape their decisions to enter the care sector, to stay in a job and to accept particular working conditions. The effects of immigration controls are therefore connected with employers' perceptions of the advantages of migrant workers. For example, we find that migrants subject to immigration

controls (work permit holders, spouses, students) tend to stay longer in jobs than EU workers, which raises questions about the implications for the continuity of service provision of the sector's currently high reliance on East Europeans.

Some of the challenges shaping the demand for migrant workers are also key determinants of the overall quality of care services. For example, continuity of employment and the relational aspects of the relationship between migrant workers and older people – language and communication barriers – are major issues also for care users. The factors influencing the quality of care will be at the core of the next chapter, which draws upon the experiences of older people and migrant workers in both residential and home care settings.

6. Experiences of the Quality of Care

This chapter analyses the factors influencing the quality of care based on the experiences of older people and migrant care workers. It considers the importance placed by older people and by migrant care workers on the relational quality of care before exploring the perceptions and experiences of older people, migrant care workers and employers of constraints within the care relationship. These include language and communication barriers and conditions within the care system that impact on the time available to provide care and on the continuity of care. The chapter concludes by emphasizing that achieving improvements in the quality of care for older people and in the working conditions of migrant care workers are related issues.

Migrant care workers interviewed in this research were foreign nationals subject to immigration controls in the UK and were predominantly recent arrivals (arriving in the UK between 1998 and 2007).⁷⁰ The data and use of the term ‘migrant care workers’ in this chapter, with reference to these respondents, are therefore distinct from the data in chapters 4 and 5 referring to foreign born care workers (which include both foreign nationals and British citizens, and both recent and non-recent arrivals in the UK). Respondents were predominantly female.⁷¹

The older people who participated in the five focus groups included current users of home care services, residents of residential care homes and members of community groups for older people who were prospective users of care provision (see appendix 4). The ethnicity of participants was White in four of the focus groups and Asian in one. Participants were predominantly female.

6.1 The relational quality of care

Overarching importance was placed, both by older people in our focus groups and by migrant care workers, on relationships in defining the quality of care.⁷² This was conveyed by older people who were residents of care homes and by those who were home care service users in terms of a ‘good carer’ being someone with whom they could talk.

‘Someone you can have a little chat with.’ (Female participant, home care)

⁷⁰ Except for three respondents who had arrived between 1990 and 1997 (see appendix 3).

⁷¹ 49 respondents were female, compared with 7 who were male (see appendix 3).

⁷² The importance of the relationship between care users and their carers to the quality of care is strongly emphasized more widely in the social care literature.

'Somebody who listens and also talks.' (Male participant, residential home)

Migrant care workers similarly referred to the quality of care in terms of the types of relationship they had with older people. Positive care relationships experienced by migrant care workers in both residential and home care settings were marked by friendship, love and trust between the care worker and user, and were often characterized as being 'familial'.

'When I am with them I just see I've got my parents or uncle.' (Female Zimbabwean care assistant, nursing home)

'We are like granddaughter and granny, the relationship is like that. We always have a good laugh, we always talk about everything.' (Female Filipino live-in care worker)

Given the emphasis placed on communication and relationship building, the need for communication and other relational skills in the provision of care was underlined both by older people and by migrant care workers. Limited reference was made to 'technical' skills, although a few care workers referred to the need to know how to operate appropriate equipment, such as a hoist, or to have 'medical' skills, such as basic knowledge of the health-related conditions of older people.

6.1.1 Communication

Communication skills were referred to by older people in all the focus groups, including residents in care homes, home care service users and prospective care users, when considering the skills required of a 'good carer'. These skills comprised listening and conversational skills.

'To listen to people, that's the most important [skill].' (Female participant, residential home)

'I think somebody who would listen to me. I think that would be important, and I am assuming that if I had care I would maybe be on my own and I suppose I would like someone I could talk to and share a bit of humour with.' (Male participant, prospective user)

Migrant care workers likewise referred to the importance of communication among the skills they required as care workers. Listening and conversational skills were considered key to meeting the need of older people for companionship, particularly those who had limited social contact with family or friends.

'To listen to these people is what they want, what they need, what they are telling me. To be like a friend with them. They feel lonely.' (Female Albanian care worker, residential home)

'To pay attention to them because they are, of course, they are lonely because they live alone. Some of them have no family at all and no one to talk to. And so, yes, listening to them is a must.' (Female Filipino care worker, nursing home)

Conditions considered to facilitate communication between older people and care workers included time:

'To give them time to sometimes speak to them, to talk to them.' (Male Filipino care worker, residential home)

As we shall see later in this chapter, limits on the time available to care workers to talk to older people inhibited this aspect of the quality of care, particularly where language and communication barriers also acted as a constraint on communication.

6.1.2 Relationship building

Other relational skills were also emphasized by older people across the focus groups and by migrant care workers as being fundamental to the quality of care. These included a care worker being loving; showing respect and empathy towards older people; being able to develop trust; and being patient.

Love

Being loving and warm-hearted were qualities that older people emphasized regarding the provision of the type of care that they wanted, involving companionship and attention to their personal needs.

'Someone who is loveable, understanding, which is the main thing.' (Female participant, residential home)

'Someone who understands our needs with affection.' (Female participant, home care)

'To show interest and consideration and kindness.' (Female participant, residential home)

Migrant care workers also emphasized the need for 'love' in developing a caring relationship with the user.

'Show them that you've got love, you know, create a relationship of some sort.'
(Female Zimbabwean care worker, nursing home)

Respect and empathy

Being 'respectful' was an additional dimension of relational skills considered important by older people. This was referred to in terms of the emotional difficulties experienced by older people in coping with a loss of independence and their reliance on the care worker.

'Someone respectful, for me, because I really don't want this being done, but since I am in this position please respect me as a human being. And if I do reject you a little bit, it's because I am having trouble coping myself. That is one of the biggest issues I would have. I'm not very good at being helped I will admit it, I have a lot of problems with my health at the moment... So, the future caring of me is scary... just the thought of being incontinent and being confined to a wheelchair, but still mentally alert, it's horribly scary, extremely horribly scary. It's just, the whole dependency aspect, it's really frightening.' (Female prospective care user)

The ability to empathize and to be attentive to the different needs of older people was identified by migrant care workers as being important to treating them as individuals, with different pasts and preferences.

'You need to find out her history, what was she before? What she liked? Whether it was stitching, watching telly, does she like writing, does she like to walk out in good dresses, does she love something like cats or dogs?' (Female Indian care worker, home care)

Trust

The importance of building trust between the care worker and user was also emphasized by older people and migrant care workers, given the private/personal nature of care as well as the dependence of the care user on the care worker, particularly regarding older people with higher levels of dependency, such as those with physical or communication difficulties.

'There's clients who have had strokes and it's hard to communicate with them. But then once you are able to establish how they communicate, they become

your best friend because they trust you to communicate things to everybody else. And you kind of know what they want, you know. So most of the clients that are my favourite clients are those that I have kind of established that communication with.' (Female Zimbabwean care worker, residential home)

Patience

Migrant care workers across care settings placed particular emphasis on the need for patience in caring for older people. This concerned the ability to cope with the emotional demands of the job, including the demands of caring for older people who had particular mental health needs, such as those with dementia, whose behaviour was sometimes seen as aggressive.

'You have to have patience. Because people who are elderly, they will have these mood swings. They have their behavioural changes. They might be aggressive or agitated. You need to have patience within you for you to take care of them properly.' (Female Filipino care worker, nursing home)

Patience was also emphasized with regard to the worker being able to take the time to be attentive to the needs of older people, including needs for companionship.

'You need to be patient. Because, you know, the people that are dependent require your attention and require your time and you need to set your time and sacrifice your time for them to satisfy them.' (Female Polish live-in care worker)

It was also considered important, particularly by migrant workers employed directly by older people to care for them in their own homes but also by other respondents, in dealing with the sometimes abusive behaviour of older people towards them.

'You have to tolerate her hot temper. Because sometimes she would shout for no reason.' (Female Indian live-in care worker, employed directly by the care user)

'Sometimes they are really very rude, talking about everybody from behind them. So we have to understand them well and we need patience.' (Female Hungarian care worker, residential home)

This aspect of the relational quality of care raises particular issues when considering direct employment relationships between older people and their carers. In the case of live-in care workers who were employed by older people or their families on domestic worker visas, the power dynamics of the working relationship had implications for the extent to which they were required to be 'patient' and 'tolerate' their employer's behaviour if they were to retain both their job and their visa. As will be discussed in the following chapter, these power dynamics also

had implications for the tolerance by live-in care workers of unfavourable working conditions, such as not being fully remunerated for hours worked.

6.2 The influence of language and communication barriers

Given the importance placed on communication and other relational aspects of care, it is not surprising that where there were language and other communication barriers between older people and migrant care workers these acted as a constraint on the quality of care.

6.2.1 English language proficiency

The limited English language proficiency of some migrant care workers was referred to by older people as one of the challenges that they had experienced (mainly with reference to East European care workers). Focus group participants who were residents in a residential home staffed mainly by White British and East European care workers referred to barriers to communicating with East European workers who had limited English language proficiency.

'There's lots of Polish girls here.'

'They are very kind, but it's the language barrier, that's the trouble.'

(Female participants, residential home)

Likewise, focus group participants in another residential home staffed by care workers from different countries of origin (Bulgaria, Romania, Ghana and the Philippines were mentioned) perceived the limited level of English language proficiency of some migrant care workers as inhibiting communication and the development of relationships with residents.

'Another point I think is the language barrier. You know, we don't understand, and you can't always joke because they don't understand the joke. It's a bit difficult but you do try.' (Male participant, residential home)

Among migrant care workers, East Europeans who lacked English language proficiency when they first started care jobs in the UK also referred to the communication difficulties that they had experienced initially in providing care for older people.

'First few weeks, what I remember, I just felt like crying. I felt like completely a fool because I couldn't speak in this language and I couldn't communicate with people. So it was very, very hard for me. And, you know, not to be able to express

myself and say what I want to say.' (Female Polish nurse, referring to experiences of working in a nursing home)

Older people emphasized the importance of English language training being provided by employers to care workers. Migrant care workers who had had limited English language proficiency when they first arrived and began working in care homes in the UK said that they had independently enrolled on English language classes at local colleges. While they had been able to access external English language programmes, participation in external programmes was not always perceived as adequate in developing English language proficiency. In part, this was because attendance of English language classes was limited due to the long hours that their jobs involved. Most care workers were not able to participate in classes during their working hours, except in the case of one care worker from Slovakia who referred to participating in classes on site (within the care home where she worked). She felt that this had helped reinforce more regular access to English language support. Access to 'on the job' assistance from colleagues with English language when carrying out care tasks was considered to be an essential source of support. However, this support was not usually available as it required time on the part of both the migrant worker and other members of staff, which was limited due to staff shortages and demanding workloads.

6.2.2 Accents

Other types of language barriers indicated by older people included difficulties in understanding the accents of some migrant care workers.

'That is a great problem is the language barrier. It's not much with the others cos they speak mostly our language, well the Philippines – they speak our language – it's Ghana and those places, I mean they do try very hard to understand don't get me wrong...'

'We don't understand them, because their accent's different.'

(Female participants, residential home)

'From African countries they've all got their own patois, or whatever you call it, accent, they all speak differently and I just cannot understand them.'

'I find it difficult when they can't understand me...'

'Difficult when you can't carry on a conversation.'

(Female participants, home care)

A few care workers who were fluent in English (from Zimbabwe and East European countries) referred to difficulties that they themselves had experienced with understanding the particular accents of older people, as well as older people not understanding their accents.

'I find it hard myself, it is sometimes hard to explain myself to older people you know, because of the accent, and I can't understand some of them, they have got a typical strong accent.' (Female Zimbabwean live-in care worker)

However, the accents of migrant care workers appeared also to act as a signifier of racial difference. Reference to accents by older people was generally with regard to care workers from African countries of origin (as referred to above). This issue will be discussed in chapter 7 concerning care workers' experiences of discrimination by older people.

6.2.3 Diversity of language and communication needs

The limited English language proficiency of some migrant care workers or difficulties with understanding differences in accents were not the only language-related barriers to communication between older people and care workers. Other language needs were emphasized by British Asian participants in one of the focus groups, some of whom had difficulties communicating in English and needed a care worker who could communicate in their first language (Punjabi).

'Someone who understands our language [is important]. Sometimes I get someone who knows my language and sometimes I don't, so there is a language problem.' (Punjabi-speaking female participant, home care)

Migrant care workers' proficiency in languages other than English could therefore *facilitate* rather than act as a constraint on the provision of care for these British Asian focus group participants, reflecting the diversity of language needs of older people. These participants referred to the level of demand in their local area for Punjabi-speaking care workers and the difficulties they had experienced in being allocated appropriate care workers (either British or Indian but proficient in Punjabi). One participant was indeed currently without any care provision as she had recently refused assistance from a care worker allocated to her by the local authority who did not speak Punjabi. A British Asian social worker who facilitated interpretation in this focus group referred to the difficulties experienced by other older people in the local area who were in need of care workers proficient in their first language, including Somali and Polish.

English language barriers were also of less concern for some migrant care workers in nursing homes who were caring for older people who had communication difficulties, e.g. as a result of

dementia or stroke. Where residents were less able to communicate verbally with care workers, other forms of communication were needed.

'With residents who maybe their dementia has progressed very, very much they just needed somebody nice with smile and, you know, that's just good for them. So, the language wasn't as important.' (Female Polish care worker, referring to experiences of working in a nursing home)

The ability of the care worker to be attentive and develop non-verbal communication skills to communicate with residents was therefore emphasized in such cases.

6.2.4 Customs

Other types of communication barrier which some older people referred to as influencing their relationships with migrant care workers included a lack of understanding of the 'customs' of older people. These customs concerned the food and drink preferences of older people. Instances of migrant care workers not knowing how to prepare a hot cup of tea or make a boiled egg, or not knowing types of food requested by older people when shopping, were referred to by some focus group participants. This lack of understanding of particular customs was seen as having a negative effect on interactions between migrant care workers and older people.

'I mention [name of care worker], she is a Hungarian girl. She has been here for about two or three months now and poor thing, it's silly little things but it made her life hell to start with. How to make a cup of tea for example, she was just making half a cup of milk and just a bit of tea. So everybody was criticizing the tea because it was cold, and I taught her how to make it. So I think there are things like that, when somebody from abroad comes here they should be taught some of the manners or the customs – how to do things.' (Female participant, residential home)

'The [care worker] who had come, she hadn't been here long and she hadn't understood what she [the user] wanted. She wanted to do a shopping list... and she came back with completely the wrong thing...'

'Yes, she didn't know what sausages were.'

'There is another case where somebody had said, [the care user] had asked if she could have a boiled egg and she [the care worker] didn't know how to do that. I mean we aren't sure whether she didn't understand, or whether she didn't quite

know how to do that. And that was something that [the care user] found very difficult.'

(Male and female participants, members of community groups for older people who were prospective users)

In contrast to the above focus group participants who were White British, some British Asian participants referred to their preferences for carers who had an understanding of Sikh customs, pointing to the diversity of customs among older people.

A need for employers to provide training about the customs of different users was emphasized by these older people. Again, this indicates the importance of time to the quality of care, in this instance in the provision of sufficient training and support to all care workers in order to facilitate the delivery of appropriate care to older people.

6.3 The influence of time and the continuity of care

As noted earlier in this chapter, our research showed that communication and relationship building were key to the quality of care for older people. The time available to care workers to talk to and develop relationships with older people was found to be fundamental to the quality of care in the experience of individuals on both sides of the relationship. Likewise, continuity of care was also an important element of the quality of those relationships.

Positive experiences of the quality of care and perceptions of migrant care workers were conveyed by older people in the focus groups in terms of care workers 'taking the time' to talk to them, and to be warm and attentive. One focus group participant expressed positive perceptions of nurses from the Philippines who had cared for her when she attended hospital visits, whom she felt had taken the time to talk with and be attentive to her.

'When I used to have to go up to [the hospital], they had quite a few Philippine nurses up there and they were so lovely, oh they were so sweet, they really were and they seemed to be extra nice and kind as they knew I couldn't see. You know, they wouldn't leave me alone and that and they would keep coming up and speaking to me.' (Female participant, home care)

Similarly, another participant who was cared for in her own home by two Polish care workers indicated her satisfaction with the care she received in terms of the level of attentiveness and time that they gave to meeting her needs. As a result, she experienced a positive relationship with these care workers in spite of some English language communication difficulties. This level of satisfaction was associated with her positive views of Polish care workers more generally.

'The one I've got is Polish and one or two things she says I don't quite understand but as soon as she has got me out of the bath, one leg at a time, you know, I've thrown me knickers on the floor to get one leg in, if she happens to pass the door and see what I'm doing, she'll come and put me other leg in, she'll give me my bra to put on as well. Very helpful... They are nice people Polish people are.'
(Female participant, home care)

By contrast, negative experiences and perceptions of migrant care workers were evident among older people who were dissatisfied with the time allocated to their care. Some of the focus group participants receiving publicly subsidized or self-funded home care through private home care agencies referred to care workers arriving late, coming at inappropriate times, not staying for the full amount of time allocated to their care visit, or not completing their duties to a satisfactory standard. As discussed in chapter 2, these experiences of 'rushed' provision negatively impacting on the quality of care have been found among the experiences of older people more widely (see CSCI 2008b). While these experiences of focus group participants did not exclusively concern migrant care workers, where they did the country of origin of the workers concerned became the focus of negative views of those workers among some focus group participants.

The continuity of the care experienced by older people was also related to the quality of that care and influenced their perceptions of migrant care workers. Positive experiences of care and perceptions of migrant care workers were evident among home care users who had a consistent relationship with their carer(s).

One focus group participant, Maureen, was cared for by Flora, a Black African⁷³ care worker who had cared for her over the past four years, originally when Maureen had been receiving publicly subsidized care through local authority social services. She had developed a consistent relationship with her carer over these years and was very happy with the care she received. However, her perceptions of this care worker differed from her views of other Black African care workers who had been sent to care for her only temporarily for short periods through a private care agency, contracted by the local authority, reflecting negative experiences of a lack of consistency of care in this respect.

'[Flora] is wonderful, I've had her four years. And over two years ago, Social Services told me, because I wanted [Flora] particularly, they told me I would have to have her privately, so I have

⁷³ Participants were not always aware of the nationality/country of origin of their carer where they referred to the carer as being African.

had her privately for two years now, but before that I had her through social services... I first had her, when I came out of hospital... And she came to me, and then when I got a bit better they took her away and then I had to have all sorts of people come in and they were diabolical – they couldn't even make a bed... The others that they sent me from the [private home care] agency, they don't know anything, I think they must live in mudhuts or something!

The quality of the relationship that Maureen had developed with Flora over time was evident in terms of her categorization of their relationship as being one of friendship.

'We are more friends than anything now, she is lovely, she really is. She is a ray of sunshine. As soon as she comes in the door it's all laughs with her. She's got a terrific sense of humour. I don't know what part of Africa she comes from, but she speaks very good English. Yes, she's very good.'

The conditions under which migrant care workers operated had implications for the time available to them to talk to and be attentive to the needs of older people, as well as for the continuity of care. Staff shortages, the rationing of publicly funded home care services, and agency working were found to have negative effects on the relational quality of care, including relationships between older people and migrant care workers.

6.3.1 Staff shortages

As mentioned in chapter 5, one of the perceived advantages of migrant care workers referred to by employers was their willingness to work all shifts. Migrant care workers themselves referred to long hours of work, including working overtime, although, as will be discussed in chapter 7, working overtime was not a simple 'choice' on the part of migrant care workers. Long hours of work were partly a result of staff shortages in care homes and the reliance of employers on migrant care workers to fill these gaps. Long hours in turn, however, had consequences for the quality of care provided to older people. Migrant care workers referred to the exhaustion of workers caused by long hours of work and the negative effects on the provision of care, such as being too tired to be attentive to the needs of residents.

The understaffing of care homes was also considered to limit the amount of time care workers were able to give to talk with and listen to residents, therefore inhibiting relationship building between migrant care workers and older people.

'If I don't have time, I can't develop a good relationship with them. I'm trying to give them as much time as I can but if there are no other staff, I just need to do other jobs.' (Female Polish care worker, home care and care homes)

'I find it too much of a rush and it's all about time. It's not about care. Because old people most of the time they need someone to talk to. It's not just about their health, they want to talk, they want someone to spend time with them.' (Female Zimbabwean care worker, referring to experiences of working in residential homes)

Having to take on additional non-care-related duties, such as cleaning, in the context of staff shortages likewise limited the time available to care workers to care for residents adequately, including time to talk with them.

Barbora, a care assistant from Slovakia, was working in a residential home with nursing facilities. The care assistants in the home, all of whom were foreign born workers, were from East European countries, the Philippines, China and India. Barbora referred to the difficulties experienced by these care assistants in delivering relational aspects of care, including taking the time to sit and talk with residents, because of the limited number of staff on duty and the need, as a result, to take on other tasks.

'The girls downstairs do a lot of washing the dishes, cleaning etc. They are doing everything, they are really being kept busy for 12 hours. They don't have much time to talk to the people because they are busy doing things which are not about the caring. Downstairs it's 40 people and four carers.'

The rushed nature of caring for older people where there were staff shortages was seen as preventing care workers not only from having time to provide relational aspects of care, but from adequately meeting basic care needs, including minimum standards of personal care. A Zimbabwean care assistant who was working in a residential home referred to the difficulties she and her colleagues experienced in ensuring that standards for the toileting of residents were met when there were not enough staff to carry out these duties.

'It's always cut down the staff. And if you cut down on staff, we can only do what we can at the end of the day... We used to have toileting in the morning, in the afternoon and before they go to bed. But now it's such that we cannot toilet them in the morning. So we get them up, and those who've got up early will stay

until the shift at three o'clock because we can't do it. By the time we've finished getting some people up, it's lunch time already.' (Female care assistant, residential home)

Staff shortages were associated with other health and safety regulations and minimum standards for the provision of care being bypassed. Examples included migrant care workers lifting residents on their own because they felt that there were not enough staff available to assist them; the responsibilities of nurses to give medication to residents being delegated to them because nurses were too busy/lacked sufficient time to do this; and not having adequate time to read or write notes on residents in their care plan, or to carry out staff handovers to agency workers in order to brief them on the needs of residents.

6.3.2 The rationing of publicly funded home care services

Focus group participants' experiences of inadequacies in the time allocated to their home care visits, such as receiving visits at times that did not match their preferences, partly reflected the lack of effective choice of those who were dependent on publicly subsidized care. One participant who was receiving publicly subsidized home care was visited by one of her care assistants to help her into bed at a time much earlier than she wanted (8.00 p.m.) as that was the only time she was offered by the home care agency. While this participant had contacted the agency about her dissatisfaction with her care, she indicated her lack of ability to make any effective demands on the agency, which was contracted by the local authority.

Care workers' experiences of the lack of time allocated to home care visits also pointed to the negative effects of the rationing of publicly funded home care services on the quality of care for older people.

Monika, a care worker from Poland, was working for a private home care agency that delivered publicly funded home care services contracted by a local authority in London. The agency was staffed by care workers from a range of countries of origin. Monika felt that the time allocated to care for her clients was generally inadequate. She referred to her experiences with one of her clients, an older man who had difficulties with walking. The client was allocated an hour in the morning for personal care, which involved helping to get him out of bed, bathed and dressed, and giving him breakfast, which Monika found very difficult to do within the allocated time without 'rushing' him. Instead, she regularly stayed an additional 30 minutes beyond the allocated time in order to give the time needed to care for him adequately.

'You can't be in hurry with this patient because he could hardly walk. He can't bend. And that's why I always stay longer because he needs a lot of help.'

Monika had informed the home care agency of the additional time she worked and, as a result, the agency was trying to monitor which clients were requiring more time than was currently allocated by the local authority with a view to informing the local authority of these cases. The provision of adequate time to care in the context of the rationing of publicly funded home care services for older people was, however, in the meantime at the cost of care workers such as Monika who were willing to give their extra time, unpaid.

6.3.3 Agency working

The consistency of the care relationship between care workers and older people was considered by migrant care workers to be key to developing trust with older people. Respondents who were working as live-in carers for older people in their own homes felt that one of the advantages of working in this care setting was that it allowed for greater continuity in the relationship.

'Because I'm always there she trusts me; we are like a family. She trusts me because I give her pills, I dress her.' (Female Sri Lankan live-in care worker)

By contrast, more limited contact with care users was referred to by migrant care workers as restricting the development of relationships with older people. In particular, those who were agency workers, working in different residential homes for limited periods of time, referred to the difficulties of getting to know the older people for whom they cared. This resulted in more distant rather than 'familial' relationships with users.

Dorota, a care worker from Poland, was balancing a number of care jobs, including doing agency work in different residential homes as well as working for a live-in home care agency to provide temporary cover for other live-in care workers. She referred to the difficulties of getting to know and develop a relationship with the people she cared for in these circumstances, given the lack of time she had when being moved from one care home to the next.

'If I don't have time, I can't develop a good relationship with them... Sometimes I forget their names. It's a shame but, you know, I can't remember every name when I'm working in 20 or 30 different homes and I meet hundreds of people. I'm trying to remember their names and to remember them, their needs, what they like, what they don't like.'

6.4 Mental health related needs and access to training and support

The mental health conditions of some of the older people for whom they cared, in particular dementia, were perceived by migrant care workers as creating challenges for developing relationships. These perceptions were based on their experiences of verbally and physically aggressive behaviour on the part of the older people concerned.

'She is suffering from dementia. I really have a hard time with her... I had to hide the knife and everything, because she many times came when I was lying down and came and slapped me.' (Female Indian domestic worker providing live-in care)

The extent to which migrant care workers had been able to access training and support in working with older people with dementia varied. Some respondents working in residential and nursing homes said they had received training in dealing with dementia from their employers. By contrast, those who were providing live-in care and were employed directly by older people/family members (as opposed to those employed by home care agencies) lacked any training or support in this respect. One live-in care worker from the Philippines, who like the respondent quoted above was employed on a domestic worker visa, had been recruited by the family of an older woman with dementia through an agency that supplied domestic workers. She referred to occasions when the woman had threatened to attack her with a knife after she had had to lock the kitchen door at night to prevent the woman from getting up during the night and leaving the toaster or oven on. The care worker emphasized the emotional stress of working under such conditions with no support or training available to her, as did others working in similar situations.

In addition to the need for English language and other communications-based training, there were therefore also concerns among migrant care workers employed in private households about their lack of access to other types of care-related training and support (which, as indicated in chapter 2, care homes and home care agencies are required to provide), with implications for the health and safety of both care workers and older people in these settings.

6.5 Conclusion

Our findings underline the importance of facilitating working conditions for migrant care workers (indeed, all care workers) that *enable* communication and relationship building with older people. In this sense the quality of care for older people and the working conditions of migrant care workers are related issues.

With regard to language and communication barriers, the findings point to the importance of adequate English language provision for migrant care workers in need of English language learning support, of a type that can be easily accessed by migrants who are working according to the demands of a '24-hour care' environment. Employers could facilitate access through the provision of English language classes on site in care homes or by allowing care workers time during their working hours to attend outside classes. In addition, time needs to be built into the workloads of managers and other members of staff in care homes and home care agencies to provide 'on the job' English language support to care workers in the context of carrying out care tasks. Difficulties with understanding 'accents' may require more interactive learning between older people and migrant workers, as well as time and consistency of contact between users and workers to establish understanding and successful communication. The findings also point to the importance of other communication-based training and support to enable better understanding of the particular needs, customs and preferences of different care users. The provision of 'culturally appropriate' care to a diverse older population in the UK requires the provision of relevant training to both UK born and migrant care workers alike.

In addition, the research raises concerns regarding the access of migrant care workers employed directly by older people to wider social care training and support, including training in caring for older people with greater levels of dependency, and the regulation of access to training for those employed in private households.

With regard to the conditions under which care is delivered, the findings underline general issues of concern regarding the adequacy of the resourcing of social care; the demands placed on *all* social care workers; and the negative implications for the quality of care experienced by older people. They also raise particular issues of concern for migrant care workers.

First, employers' reliance on migrant care workers to care for older people under conditions that UK born workers will not accept may enable care homes and home care agencies to continue to operate within the resource constraints of the care system – providing low-cost care within the budget limitations of local authority commissioners of care provision. However, the effects of resource constraints on staffing levels, time to attend to the needs of older people, and the provision of training and other support and supervision have implications for migrant workers providing care under such conditions. These include cost implications for those working beyond their contractual commitments to compensate for the inadequacies of the system (e.g. by working overtime in care homes or allocating unpaid time to home care visits).

Second, there may be negative consequences not only for the overall quality of care experienced by older people, but specifically for relationships between older people and migrant care workers. A lack of time to talk to and understand the needs of different care users may be particularly difficult for care workers with English language learning needs to manage. It

may also exacerbate language and communication barriers. Likewise, negative experiences of care delivered under pressure of time may contribute to negative perceptions among older people of migrant care workers on grounds of ethnicity/migrant status as opposed to the inadequacies of the conditions under which their care is delivered.

7. Inequalities, Discrimination and Access to Employment Rights

Chapter 5 showed how the migrant social care workforce is differentiated by immigration status and how the impact of immigration controls – on migrant care workers’ ‘willingness’ to stay in a job and accept particular working conditions – is connected with employers’ perceptions of the advantages of migrant workers. These findings point to the implications of demand for migrant workers on the production of inequalities in the care sector, both between migrant and British care workers and among migrant workers. This chapter focuses on migrant care workers’ experiences of inequalities and discrimination in the care sector and on their access to employment rights, also drawing on relevant findings from the interviews with employers and from the focus groups with older people. It explores how inequalities, discrimination and access to employment rights are shaped by race and immigration status as well as by conditions within the social care system. The first section focuses on employment relations (between migrant/British care workers and managers/employers), while the second section focuses on relations between migrant workers and care users. The third section then examines processes for accessing employment rights and addressing discrimination in the care sector, bearing in mind the legal position set out in chapter 3. The chapter concludes by summarizing the key findings and implications for the regulation of the employment of migrant care workers and for addressing the attitudes towards migrants that can result in discriminatory practices.

7.1 Inequalities and employment relations

Inequalities and discrimination in employment relations on grounds of race and of nationality were evident in migrant workers’ experiences of working in the care sector. These experiences are explored below with regard to the following aspects of employment relations: the allocation of hours of work and the tasks involved; the wages and social protection of workers; access to training opportunities and promotions; and complaints, disciplinary and dismissal procedures. The legal framework for addressing inequality was set out in chapter 3 (section 3.8.1).

7.1.1 Hours and tasks

One dimension of inequalities experienced by migrant care workers concerned the number of hours of work and the type of shifts and tasks involved.

Residential and nursing care homes

Longer working hours

Migrant care workers referred to the long hours of their work in care homes, involving regular overtime beyond their contractual hours of work. Indeed, as indicated in chapter 4, foreign-born social care workers, and in particular recent arrivals in the UK, are more likely to be in full-time work and to work on average longer hours than UK born social care workers.

Working long hours was partly related to the low wages of the care sector. For some respondents, working overtime was a coping strategy to top up low pay as a means of generating an adequate income to cover the costs of living and in some cases to meet caring responsibilities for family in the UK or countries of origin.

'I work more or less 50 hours per week... so that I can compensate my tax, yeah. Because if I work only 37 hours, 37.5, and then they will get my tax, nothing left for me. And then I will pay my rent, my transport, my bus, my food. Nothing left for my family. So, you really work more hours. That's why. Maybe if they increase the wages, you won't need to, you know, work more hours.' (Male Filipino senior care assistant, residential home)

Overtime work was also sometimes required of migrant workers by managers of care homes as a strategy for dealing with staff shortages. Some respondents referred to the unwillingness of managers to pay for additional staff despite the heavy workload of care workers, including unwillingness to hire agency workers to provide additional cover during periods of staff turnover, sick leave or holiday, because of the extra costs involved. As permanent staff were not paid a higher rate for overtime, some respondents indicated that their managers preferred to rely on them to work additional hours rather than pay higher rates for agency workers.

Less favourable shifts

In addition to working long hours, respondents also referred to working less favourable shifts than British care workers, such as weekends or night shifts. A female Polish senior care worker in a nursing home described her experiences of the unfair division of weekend shifts between migrant workers from Poland and the Philippines and English care workers.

'For two years, every single Saturday and Sunday I was at work... I think it was most of the Polish people and Filipinos. It didn't happen with English carers. Apparently they explain to us that they don't have in their contract that they have to work every weekend, but I didn't have in my contract that I have to work every weekend. I had in my contract that I have to work 150 hours a month. It was hard and sometimes I felt that it's not fair because it never happened with

English carers, not in my unit. It was always Polish people. If you would go every single weekend there you wouldn't find any English person, it's always Polish staff or Filipino staff during the weekend.' (Female Polish nurse)

These divisions in the allocation of shifts between migrant and British workers were considered by migrant care workers to be related to staff shortages within the care system, including overall shortages as well as a lack of British staff willing to work the hours/shifts involved in '24-hour' care for older people. Managers/employers were perceived by migrant workers as being dependent on full-time migrant staff working unfavourable shifts that part-time British staff were unwilling to do. The respondent quoted above indicated that since only Polish and Filipino staff were employed full-time in the nursing home where she worked (as British staff worked part-time due to caring responsibilities for their children), her manager had little option but to allocate weekend shifts to these workers.

'My manager really tried hard to give us some weekends off but she couldn't because we have few other people who was employed or full-time... it was only few of us and it was Polish and Filipinos.'

The dependence of managers on recently arrived migrant workers working longer hours and all shifts to fill staffing gaps was also considered to be related to the high turnover rates of British staff in some care homes. A Filipino care worker who had previously worked in a residential home in Scotland referred to sometimes working between 48 and 70 hours a week, while contracted to work a 36-hour week, in order to cover Scottish staff leaving their jobs after short periods of a few months or calling in sick and not showing up to work when they had been 'out drinking'.

Unfair division of tasks

In addition to divisions in the allocation of hours of work, migrant workers noted inequalities in the division of tasks between care workers, based on race or immigration status. Some Zimbabwean respondents referred to managers or senior care workers allocating the 'harder tasks' or the more 'difficult residents' to Black African workers as opposed to White care workers who were 'friends of the management'.

'They prefer to give good people to the white carers.' (Female Zimbabwean care worker)

Divisions were indicated not only between White British and Black migrant care workers but also between White East European and other migrant workers. A female care assistant from China who held a work permit referred to being allocated harder work, in terms of the amount of tasks and lack of breaks, by the White British and East European managers and nurses in the care home where she worked, who she perceived as favouring East European care assistants.

'They are quite a strong team here, mostly from Slovakia... The [Slovakian] nurse on duty every day always give me hard work. I never rest.' (Female Chinese care worker, private nursing home)

Discrimination in favour of White East European workers in the allocation of tasks in care homes was perceived by migrant workers as being shaped by the interaction of race, immigration status and managers' difficulties in retaining staff. Preferential treatment of White East European workers was considered by the respondent quoted above to be motivated by managers' concerns to keep East European staff who were more likely than others to leave the job, given their freedom to do so as EU nationals.

Home care provisions

Insecurity of hours of work

Migrant workers employed by home care agencies emphasized the insecurity of their hours of work and the implications for their pay. Hours could change from day to day, with no guarantee of a minimum number of hours work each week. In addition, they referred to the difficulties of being required to travel from client to client in order to provide home care for the varying times allocated to the older people for whom they cared, with no remuneration for travel time.

'Sometimes in home care I can have about 1 hour, 30 mins, sometimes it can go for 6 hours a day. Sometimes you can work for days continuously, sometimes you can go for days without working... Sometimes you have to spend your own money to go and do work that will be almost equal to the fare that you spend.' (Male Gambian care worker, home care agency)

The flexibility of working hours experienced by migrant workers, and the lack of remuneration for all hours worked, appeared to be influenced by public funding constraints within home care provision, according to the experiences of managers of home care agencies interviewed in the research. Managers of agencies contracted by local authorities to deliver publicly subsidized home care services to older people described the difficulties of operating as a provider under conditions of limited funding.

Lack of agreement on hours of work

Live-in care workers emphasized the undefined nature of their weekly hours of work. The lack of regulation of working hours was associated with situations where migrant workers were employed directly by older people/family members, without an intermediary, such as a home care agency, to negotiate and monitor the terms and conditions of employment between the worker and care user/employer. Among domestic workers providing live-in care (who were recruited by word of mouth or by agencies supplying domestic staff), both those who had an

employment contract setting out their hours of work and those who had only a 'verbal agreement' as to the terms of their employment indicated that they were sometimes required to work six or seven days a week, including on agreed days off from their care duties, according to the needs of the person for whom they cared, who was also their employer.⁷⁴ They referred to being on call '24 hours a day' and, if they took a break, being made to feel uncomfortable by older people/family members who expected them to be working continually 'to get their money's worth'.

'There's no agreement on that [hours of work]. I don't have that. I work continuously, continuously, continuously, provided I'm in the house, you know, continuously, continuously.' (Female South African live-in care worker, directly employed by the care user)

In some cases, the needs of the employers of care workers providing home care (e.g. both home care agencies and older people) and the purchasers of home care (e.g. local authorities and family members) for 'flexible' care workers coincided with the needs of migrant care workers, such as students, for flexible hours of work. However, a lack of *clarity* about weekly hours of work in home care provision required a high level of flexibility on the part of migrant care workers with cost implications in terms of their wages – by being underpaid for the actual hours of care work they provided. This point is explored further below.

7.1.2 Differences in wages and social protection

Another dimension of inequality based on race and nationality experienced by migrant care workers concerned their wages and social protection. A male Zimbabwean respondent, who had worked in both care homes and home care settings, described his experiences of East European, African and Asian care workers receiving lower wages than British workers in equivalent work.

'It's not only the day to day treatment that you get at work, but even the wage range, where most people of British origin, or British citizens, get paid more than other people from Eastern Europe, Africa, or Asia who will be doing the same work, same hours, or even working more than the people that are getting paid more.' (Male Zimbabwean care worker)

⁷⁴ This was sometimes due to a relief worker not being in place to provide cover for the care worker because the older person/family members were unwilling to pay for cover or felt that it was unnecessary.

Similarly, a senior care worker from the Philippines referred to experiences of Filipino workers receiving lower wages than British senior care workers at the nursing home where she was employed, which was owned by a large care group.⁷⁵ Indeed, as noted in chapter 4, LFS data show that foreign born care workers – both recent and non-recent arrivals to the UK – are over-represented at the lower end of the pay scale in social care compared with their UK born counterparts, with higher proportions earning below the National Minimum Wage.

In addition to differences in pay, migrant workers referred to other experiences of being underpaid, including not being paid for working overtime or wages being withheld by their employers. These experiences were partly shaped by immigration status: as indicated in chapter 5, ‘irregular’ care workers (including those who had overstayed student visas) referred to managers of care homes being able to withhold their wages because of the irregularity of their status and their fear of voicing complaints. The type of employment relationship was also significant. A lack of regulation of wages as well as of working hours was evident in cases where migrant care workers were employed directly by older people/family members to provide live-in care, again particularly where a home care agency was not involved as an intermediary. First, live-in carers were paid a weekly rate (in contrast to the hourly rate paid by care homes). Given the long hours of work sometimes required of live-in carers, their actual hourly rate of pay in some cases fell below the National Minimum Wage when accounting for the actual number of hours worked each week. Second, live-in carers directly employed by older people/family members were sometimes not paid for working overtime, such as working on days off agreed with their employer. Third, they were in some cases not paid their full wages each week, including cases where older people ‘forgot’ to pay their wages, or were not paid at all, as in the case of one care worker from India.

Deshna, who came to the UK from India on a domestic worker visa, had been working as a live-in carer for an older man with physical disabilities, while also carrying out domestic work within the household where the man’s wife and son were also living. She had a verbal agreement with her employer (the wife) that she would be paid the same weekly rate of £650 as the Australian care worker whom she was replacing. However, after starting work, Deshna’s employer gradually reduced this rate of pay to £350 when Deshna asked to be paid each week. After an extended period of trying to negotiate her wages, Deshna eventually left the job with wages that amounted to £5,000 still owed to her.

⁷⁵ She and other Filipino workers in this care home had collectively discussed the matter with their employer (the care group). The manager of the care home had eventually agreed to give Filipino workers the same rate of pay as their British counterparts.

'Whenever she opened her mouth [the pay] went down and she never paid... I said "I need the money, I really need it." I had been patient and waited, and asked her in a nice manner. "I have come in a nice way to you, I have worked for you, I have sacrificed a lot, and you have to pay me." She said, "I will pay." Every time she said, "I will pay, I will pay, I will pay." If you ask her about money she gets angry and finally she said, "I will not pay you." She said to leave.'

Direct employment relationships between migrant care workers and older people/family members were also associated with limited access to social protection for migrant workers. Some domestic workers who were providing live-in care found that older people or family members were avoiding their responsibilities for employee tax and national insurance contributions in addition to wages as a means of cutting the costs of care. A female domestic worker from the Philippines described her experience of taking up a live-in care position in a private household through an agency that supplied domestic workers. The agency informed her that the employer (the daughter of the elderly couple for whom she would care) wanted to pay her partly in cash as a means of tax avoidance. After the respondent disputed this with the agency, on the grounds that this might have cost implications for her in terms of her future pension rights, the employer agreed to declare her full salary.

Employing migrant workers on a 'self-employed' basis appeared to be another means of older people/family members avoiding tax and national insurance payments. While reducing the labour costs of care for older people or their family members as employers, this strategy again had cost implications for the worker.

Grace, who came to the UK from the Philippines on a domestic worker visa, was working as a live-in carer. She described her experience in a previous job where she provided domestic help for an older woman by whom she was directly employed. Grace had been told by her employer when she started the job that she was 'self-employed' (although self-employment would have been prohibited under the terms of her domestic worker visa). When she was required to take sick leave due to a health condition, Grace was immediately dismissed by her employer and, given the irregularity of her employment, was not entitled to statutory sick pay.

'My employer was so mad at me. She said, "I'm the one who signed your papers to get you work here and to get you stay here for another year"... So for about two months I didn't work because of this haemorrhoid problem. Thank God that I have a Filipino friend who helped me to stay in her flat until I get better. I didn't ask for any compensation or even the government to give me some money because what for, I didn't pay tax and my employer didn't pay tax and insurance.'

The disregard of the employment rights of migrant workers employed directly by older people or their families was therefore associated with the shifting of the labour costs of care, including not only wages but also the costs of social protection, on to migrant workers and communities.

7.1.3 Less access to training opportunities and promotions

Migrant care workers also referred to experiences of inequality in access to social care training opportunities and promotions. These experiences were partly shaped by race. Preferential treatment towards White care workers, for example, was referred to by a female Zimbabwean care worker in the context of one care home where she had previously been employed.

'If there are any promotions at work or any training courses, the manager will take the white first and you will be the last one to be selected.'

Similarly, a care worker from Kenya, who had a background in nursing, referred to the unfair treatment of African care assistants who were denied opportunities for promotion to senior care worker posts offered to White care assistants in a care home where she had previously worked, despite the higher level of qualifications and experience of the African care assistants.

Experiences of inequalities in access to training opportunities *among* migrants – between East European and other migrant care workers – were also shaped by immigration status. While East European care workers, as EU nationals, were entitled to access publicly funded NVQ training in social care after three months of employment in the UK, non-EU nationals were required to have been resident in the UK for three years first.

7.1.4 Complaints and disciplinary and dismissal procedures

Unfair treatment of migrant care workers with regard to complaints and disciplinary and dismissal procedures was also described by some African and Asian care workers. This was considered to be on grounds of race and nationality. A male Zimbabwean care assistant referred to the unfair dismissal of African and Asian care workers in contrast to White British workers in a care home where he was working.

'Somebody might do something, someone of another nationality, and then they will be called in the office and maybe told off or promised they will get the sack and then a White person does the same thing, they won't have been told off at all. So it's really, really sad and you can tell that there is a little bit of favouritism between the races or the people and the treatment of each.'

Similarly, a Filipino senior care assistant referred to ‘foreigners being discriminated’ against in the nursing home where she was employed, which suspended a number of migrant workers (who she indicated were from the Philippines, Africa and India) on grounds of allegations made by White British members of staff of abuse of residents. She felt that the White British care workers had made these allegations because of their resentment towards migrant workers who held more senior positions as senior care workers. While it was the responsibility of senior care workers to delegate tasks to care workers, she indicated that White British care assistants refused to follow duties delegated by ‘foreigners’.

Racial discrimination in the context of complaints and disciplinary and dismissal procedures was not confined to experiences of discrimination by White British managers and staff towards migrant care workers, given the diversity of staff in some care homes where respondents were working. Other incidents also included discrimination against Black African care workers by White South African or Black British managers in care homes, pointing to more complex power relations based on race and nationality within the social care workforce.

7.2 Inequalities and relations with care users

Another dimension of inequality within the care sector concerned racial discrimination in the context of older people’s preferences for who provided their care and their treatment of migrant care workers.

7.2.1 Older people’s preferences for care workers

The influence of race/ethnicity in shaping needs and preferences for care as well as use of care provisions has been documented in the social care literature (e.g. in the UK, Mold et al. 2005; Bowes, 2006; and abroad, Berdes and Eckert 2001; Jönson 2007; Neysmith and Aronson 1997), and we have referred to employers’ experiences in this respect in chapter 5. Experiences of negative attitudes and behaviour towards ethnic minority staff have been reported in the research literature on the care sector in the UK and abroad. Although research on this issue is limited, there is evidence relating to all service users, not only older people. A survey of public sector social services staff found ethnic minority staff had experienced racist verbal abuse from service users; inappropriate questioning of their authority by users or relatives; users not wanting to be touched by them or asking to be dealt with by a White person (most frequently occurring in the user’s own home); and physical attacks perceived to be racially motivated. Inappropriate remarks from colleagues were also experienced (Brockmann et al. 2001). Research on Zimbabwean carers found that carers in residential homes for older people

experienced verbal abuse from clients and many had been told they 'did not want to receive personal care from a black person', although some reported managers and clients expressing a preference for Zimbabwean/Black/migrant carers who were seen as 'hard working' (McGregor 2007). A Swedish study reported similar experiences, with service managers more likely than front-line ethnic minority care workers to suggest that this kind of occurrence was rare. Complaints by service users and relatives about problems in language and understanding among ethnic minority staff were in some cases perceived by service managers to be motivated by racism but in others to be based on a legitimate concern (Jönson 2007). This suggests that, while some of the experiences of migrant care workers in our study related to their status as migrants and experience of migration, other experiences may be shared by UK born ethnic minority care staff.

In our focus groups race/ethnicity and country of origin were found to contribute to older people's preferences for and attitudes towards care workers. Among the focus group participants, some older people expressed preferences with regard to the race/ethnicity or country of origin of a care worker, although overall participants did not consider the ethnicity of a care worker 'to matter'.⁷⁶ In one focus group carried out in a residential home staffed mainly by White British and East European care workers, a few White British participants expressed preferences for 'English carers' for language reasons, placing greater emphasis on the English language proficiency of English care workers as opposed to their ethnicity or country of origin.

'Well, I'm not being biased, but I like the English girls. I think the trouble, it's these barriers that causes the trouble. Like especially the language. And they get it wrong at times. They misunderstand and then they get things wrong... The Polish girls seem to have dominated in my life and they were the ones for who, you know, the language was very bad.' (White female participant, residential home)

The influence of ethnicity or country of origin on older people's preferences for care workers was also partly evident in a focus group with British Asian participants who were receiving publicly funded home care services, some of whom expressed preferences for Asian (British Asian or Indian) carers. Again, they related their preferences to their language needs: participants who had difficulties communicating in English needed an Asian care worker who was proficient in Punjabi, their first language, in contrast to those participants who were proficient in English.

'I can speak English so I don't mind which carer it is... it's easy for me to be with my carer.'

⁷⁶ However, focus group participants may have been reluctant to express their preferences with regard to race/ethnicity in a group setting or with the interviewer.

'But I would want someone typically Asian, who speaks my language so I can communicate.'

'I don't mind if the carer is white or Asian or black as long as she can share her language.'

(Female and male British Asian participants, home care)

Preferences were also partly shaped by religious needs. A social worker who carried out interpretation in this focus group indicated that among the local Asian population, which was predominantly Sikh, female older people preferred to have a female Asian care worker with knowledge of Sikh customs in order to provide 'culturally appropriate' care.

As discussed in chapter 6, these findings point to the influence of language and communication barriers in contributing to older people's attitudes towards (migrant) care workers. They also point to the diversity of language needs among older people and how demand and preferences for migrant care workers may be related to the particular language skills of those workers. However, the influence of race/ethnicity or country of origin on preferences for care workers was evident beyond the issue of language needs. In a focus group with older people who were prospective care users, preferences for British care workers among some participants were defined in terms of wanting a care worker with whom they could share the same sense of humour; or in terms of trusting the care worker to care for them in their own home, with reference made to differences in the 'attitude' of migrant care workers with different social and cultural backgrounds from the care user. Preferences were also in a few cases defined directly in terms of race: one participant in a focus group with White British home care users indicated that although 'colour shouldn't matter', for her it did. Indeed, as will be explored in the following section, race discrimination evidently shaped some migrant care workers' experiences of the 'preferences' of older people.

7.2.2 Race discrimination towards migrant care workers

The influence of race/ethnicity on older people's preferences for care workers – and the ways in which those preferences were articulated, e.g. in relation to language needs, religious needs, or purely on the basis of skin colour – raises issues regarding migrant care workers' actual experiences of discrimination in caring for older people. It also raises issues regarding employers/providers' perceptions of their responsibilities and their experiences of negotiating the preferences of older people alongside ensuring that their care workers are not subject to discrimination.

Experiences of verbal harassment and of race discrimination by older people were referred to by some migrant care workers, in particular those from Zimbabwe or other African countries. These experiences included verbal abuse from older people and older people refusing to be cared for by Black care workers, both in residential and nursing care homes and home care settings.

'There's a resident that can say, "I don't want black people. Don't touch me. You are black. Go back to your country."' (Female Zimbabwean care worker, referring to experiences of working in a residential home)

'Where I used to work, there used to be a woman who said, "Can you send me a carer but not a black one please."' (Female Zimbabwean care worker, referring to experiences of working for a home care agency)

'Most of them really they are racist, they can't help it. And they make it really open that they don't like you.' (Female Zimbabwean care worker, referring to experiences of working in residential homes)

Respondents from the Philippines, China and India also referred to experiences of verbal abuse directed towards them in contrast to the treatment of White British care workers.

'We have one lady who made me angry because she says she doesn't like foreigners because they come from poor country and just want money.' (Female Chinese care worker, nursing home)

'Sometimes, the way they speak to you. It's like they're rude or they're treating you like slaves because you're a foreigner. But when they're speaking to their own kind, you know what I mean? What they say to their own people, it's different. They talk to them in a friendly manner.' (Female Filipino care worker, residential home)

Other dimensions of race discrimination conveyed by migrant care workers included the unequal treatment by older people of African and Asian care workers, compared with White care workers, regarding the level of attention to their needs that they demanded.

'They want us to attend to them more. When you work with a white carer, it's funny, you seldom find the resident rings the bell. It's because maybe they know that they won't be attended or whatever. But if they see that it's foreigners, they need you to do more for them'. (Female Filipino care worker, nursing home)

While East European care workers overall did not refer to experiences of racism directed towards them, they did note racism towards Black colleagues in care homes and home care

settings. Indeed, some East European respondents felt that they were favoured by older people because they were White.

'A few clients don't really like Asian or African carers. They saw me as a white person and they are much friendlier.' (Female Slovakian care worker, home care)

'We have some problems sometimes because elderly people doesn't like black carers... I've worked with some client and she really didn't like black people and she said she never want them around her.' (Female Polish care worker, nursing home and home care)

Migrant care workers' rationales for the race discrimination that they had experienced partly corresponded with the rationales given by older people for their preferences for care workers on the basis of ethnicity or country of origin.

Communication barriers, where older people had difficulties communicating with a care worker because the worker lacked English language proficiency or the older person was unable to understand the worker's accent, were considered by some migrant workers to provoke verbal abuse.

'If you have like people from different nationalities struggling with the English language and they can't communicate to the clients, it's just frustrating in the sense that they might do things that the client doesn't want to have done. But then it's the communication barrier that you have usually. So, it's not maybe that they hate a person, where they are from or anything, but they can't understand each other.' (Female Zimbabwean care worker, residential home)

However, language, including the accent of migrant care workers, also acted as a signifier of racial difference in experiences of discrimination. A female Zimbabwean live-in care worker referred to the older woman for whom she cared pretending that she was unable to understand her accent when other White care workers came to her home.

'She likes white people more than me. Sometimes, when she talks to me, she will know what I'm talking about, but if she sees other white people, she will say she can't hear what I'm talking about, "I can't hear your accent, what are you saying."'

Racism was considered by some care workers to be generational, typical of the attitudes of older people.

'If you're an African, some of these elderly people, you know their generation, they are racist.' (Female Zimbabwean live-in care worker)

For others the 'challenging behaviour' of older people with particular mental health conditions, such as dementia, was identified as a reason for race related verbal abuse. Other respondents also identified a fear of or lack of trust in 'foreign' care workers on the part of older people.

'Most clients respect white people. They tend to have more respect and trust in white people. Maybe it's due to cultural things but I personally think that it is a lack of confidence in mostly foreign carers. Until you get to know them, and then until they know you they might start to begin to trust you, but if you just walk into their room, the elderly person will have to find levels of trust.' (Male Zimbabwean care worker, home care)

A few respondents referred to the 'preferences' of not only White older people but also older people of other ethnic groups to be cared for by care workers of similar ethnic backgrounds, reflecting the ethnic diversity of older people and how this may shape older people's care preferences and care workers' experiences of discrimination based on race/ethnicity.

'This Chinese lady, she's had different carers. The last one is from her country, she's Chinese, but she's had a Muslim girl and she's had a black girl there. But I think she was not satisfied. And I think not only that, I think some [older people] do request who they want and who they don't want.' (Female Zimbabwean care worker, home care)

The challenges that employers reported in this context are discussed in chapter 5.

7.3 Processes for access to employment rights and for addressing discrimination

Experiences of inequalities in employment and relations with care users point to concerns regarding migrant care workers' access to employment rights and procedures for addressing discrimination in the care sector.

7.3.1 Access to information, advice and redress

A lack of access to information and advice on employment rights was perceived by migrant care workers as contributing to employers' abuse of those rights, such as withholding migrant workers' wages or paying them lower rates compared with British workers.

'If you are coming from a foreign country you tend not to know the rules and regulations, the laws that govern. So on one side you can argue that this might be a racial issue but at the same time you can argue that it might be just

[employers] taking advantage of people that don't know the law.' (Male Zimbabwean care worker, home care agency)

Limited access to information and advice on employment rights was noted in particular by migrant workers employed directly by older people/family members, including those holding domestic worker visas and working as live-in carers, who in these more isolated environments were more dependent on informal networks for sources of information. However, some care workers employed by care homes or home care agencies also expressed difficulties in understanding their rights, including difficulties with accessing information through their managers.

'If you have some problems, they [managers] not very often help you. Like for example, with your employment rights, you couldn't find some information. If you ask, they look at you like you've done something wrong. And it is very difficult to find something about.' (Female Polish care worker, working for a nursing home and a home care agency)

The complexity of the employment status of some migrant care workers also contributed to difficulties in understanding the employment rights accorded to their status. This complexity concerned respondents who were contracted by home care agencies and were paid by the agency in the case of clients whose care was publicly subsidized by local authorities, but directly by older people in cases where clients were receiving direct payments or self-funding their care. In addition, some respondents (who were EU nationals or had indefinite leave to remain) were 'self-employed' when paid directly by older people, at the same time as being 'employees' or 'workers' contracted by agencies (see appendix 3 for details on the employment relationships of the migrant care workers).

Migrant workers also had limited access to means of redress to settle disputes with employers, again particularly in the case of direct employment relationships with older people/family members. This included the experiences of live-in carers (who held domestic worker visas) not being fully paid for their hours of work or their hours of work extending beyond what was contractually agreed with their employer. In cases where migrant workers were recruited through home care agencies, these agencies had sometimes mediated direct employment relationships with older people/family members, including negotiating the terms and conditions of the care worker's contract and monitoring hours of work and payment for hours worked. They therefore played an important role, for some care workers, by ensuring that older people and their families observed their carers' employment rights. However, this depended on the quality of the agency concerned: as indicated previously, one care worker recruited through an agency supplying domestic staff referred to the agency trying to negotiate with the worker

that she accept being paid partly 'cash in hand' to enable the employer to avoid employee tax contributions.

Difficulties in resolving disputes with employers were also experienced by some migrant workers employed by private sector care homes or care groups. Among those working in care homes, a few respondents referred to support they had accessed through a trade union in resolving disputes (see below). However, others, who were not members of a trade union, referred to the limited ability of individual migrant care workers to negotiate with their employers. A female care worker from Slovakia recounted the difficulties she was currently experiencing in resolving a pay dispute with her employer, a large care group that owned the nursing home in which she worked.

'Our company has about 400 nursing homes and if you have a problem there is no possibility to reach the highest boss. The company owes me £100 but it takes six months and they are still not able to send the money. They say that it's a long process which takes time and the money will come, but you never know when. You feel lost in the system.' (Female Slovakian care assistant, nursing home)

While these experiences of limited means of redress in relations with social care employers may be shared with British care workers, migrant workers' potentially more limited understanding of their employment rights in the UK may add to the difficulties of exercising those rights in negotiations with employers. Furthermore, insecurity of immigration status was found to contribute to the reluctance of some migrant care workers, including work permit holders as well as those with 'irregular' status, to exercise their rights in their relations with employers through complaints procedures, as discussed previously in chapter 5.

With regard to experiences of race discrimination in care homes, respondents were often aware of their general right to non-discrimination in employment. However, access to effective procedures for addressing discrimination in care homes, including procedures for dealing with migrant care workers' experiences of discrimination by members of staff, was limited. A female Zimbabwean care assistant, who had previously worked in a care home owned by a large care group and staffed predominantly by White British care workers, said that Black African care workers were subjected to racist verbal abuse by White members of staff. The abuse had been reported to the manager of the care home, but the response of the care group was simply to move one of the Black African workers concerned, who was from Zambia, to another care home.

'It was a more white home... And the blacks were just coming – a few. So for them [the White British workers], to accept us, it was very hard. The other nurse from Zambia, she was abused very much. She wanted to report to the managers.'

But what they did, instead of removing the white carers they removed the nurse to London to another nursing home. They got rid of that person.'

Other senior care workers from the Philippines similarly expressed their frustrations with the lack of action on the part of care home managers to address discrimination by staff towards migrant care workers when such incidents were reported.

'Discrimination is a major offence in our company. You know, it's one of our policies. They [the White British care workers] should be disciplined about it. We spoke to the manager about it but the only reply that we got was, "All right, we will tell her." But are they disciplined? No, because they're British, they're whites. We already complained loads of times. But did they do anything about it? They didn't.' (Female Filipino senior care assistant, private nursing and residential home)

The role of trade unions in providing support to migrant care workers in dealing with race discrimination was indicated in the context of the experiences of one care worker from Zimbabwe regarding a care home where she had previously been employed. She described how several Black members of staff had faced dismissal, on the grounds of what she referred to as unjustified claims of mistakes in their work by White members of staff, until their trade union intervened. However, there appeared to be limited alternative means of redress for migrant workers who were not members of a union when confronted with the inaction of managers towards reported cases of discrimination.

7.3.2 Action to address harassment and discrimination

Migrant workers' experiences of procedures for addressing race discrimination in the context of relations with care users varied. Those providing care to older people who employed them directly clearly lacked any means of reporting to their employer incidents of race discrimination by the care user. Moreover, these respondents lacked confidence in reporting their experiences externally due to the 'private' nature of care in home-based settings.

'Who is going to witness? There is nothing to prove that. So that's why I just kept quiet about those things.' (Female South African live-in care worker)

In addition, the reliance of the migrant care worker on the care user/employer for their immigration status (for those employed directly by older people or family members on domestic worker visas) also contributed to reluctance to voice experiences of discrimination.

By contrast, migrant care workers who were providing home care services through home care agencies indicated that they had been able to report such incidents to the agency concerned. Likewise, those working in residential and nursing care homes had reported their experiences to managers. However, the *responses* of home care agencies and care homes to these incidents varied. Some respondents indicated that their managers had taken steps to communicate to older people that it was not acceptable to refuse to be cared for by someone on grounds of race.

'The agency I work for, they emphasize that they don't tolerate this. So if anyone ganged up on a black person or an Asian, they will send a person there, because they seriously do not want to put up with it.' (Female Zimbabwean live-in care worker)

Other respondents indicated that where older people refused to be cared for by a Black care worker or were racially abusive towards the carer, managers' means of dealing with these situations involved avoiding placing Black care workers with the older people concerned.

'On the risk assessment with the client they try to find out everything about them. And if they notice something like that they don't direct some black carers to them... they don't want to make them upset or worse.' (Female Polish care assistant, private nursing home and care agency)

In some cases, there appeared to be a lack of any action on the part of managers to address race discrimination towards their workers by older people.

'The only thing that you can do in this kind of work is walk away. You can't really answer back, you can't really do anything about it, the only thing that you can do is probably walk away and set up an incident report and issue an application for a management hearing... You can report it to management, but most of the time nothing really happens.' (Male Zimbabwean care worker, home care)

Indeed, migrant care workers were in some cases required by managers to care for abusive clients on grounds of their professional obligations to provide care.

'The manager said "There's nothing you can do. When she [the client] says that, you walk away from the room and go back again," because I reported it. Then I said, "I don't want to go to that room any more." But the manager said, "You have no choice. A carer has to go there." They said, "If you don't, if you leave her like that, it's abuse." But the resident was abusing me.' (Female Zimbabwean care worker, referring to experiences of working in a residential home)

Zimbabwean care workers also referred to older people not always having the option of 'choosing' their carers, given the lack of British care workers and the reliance of home care agencies and care homes on migrant workers to provide care.

'Sometimes you are put in a situation when you are not really welcomed in the house, but the client doesn't have a choice who they have to put up with and we have to put up with them.' (Female Zimbabwean live-in care worker)

7.4 Conclusion

As indicated previously in chapter 2, structural inequalities based on gender and on race are evident in the social care workforce. Social care is a low-paid sector of the labour market in which the work is predominantly carried out by women. It is also a sector in which Black and Asian minority ethnic groups (both British and foreign nationals) are over-represented. The findings of the research referred to in this chapter and in chapter 5 show how immigration status interacts with race and with gender in shaping migrant care workers' experiences of inequalities and discrimination.

Migrant care workers' experiences of inequalities in employment relations based on immigration status and race included differences between British workers and foreign nationals in the number of hours and type of shifts of work. These were perceived by migrant care workers as being partly related to staff shortages and the reliance of employers/managers on migrant workers to fill gaps in staffing. Other inequalities experienced by migrant workers included direct race discrimination by other care workers and differences in access to training opportunities between migrant and EU/British workers, reflecting the differential entitlements attached to their status.

There were also differences between groups of migrant care workers regarding their working conditions. A lack of regulation of the terms and conditions of migrant workers' employment, including hours of work and wages, was particularly evident in cases where migrant workers were directly employed by older people or their families.

Inequalities in relations between migrant workers and care users concerned experiences of harassment and discrimination by older people towards migrant workers, including verbal abuse relating to race and older people refusing to be cared for by Black care workers. Language or religious needs sometimes shaped older people's preferences for care workers of particular ethnicities or countries of origin, in addition to direct forms of race discrimination.

The research raises issues regarding the access of migrant care workers to employment rights, and the influence of social care reforms and regulation on access to rights.

First, the findings point to possible tensions between, on the one hand, policy aims for greater 'choice' for older people and 'control' over their care through the implementation of cash-for-care schemes such as direct payments, and, on the other hand, ensuring access to employment rights for all care workers. The individualization of employment relationships in the provision of home-based care through direct payments, individual budgets and self-funding arrangements may conflict with ensuring that the rights of care workers directly employed by older people are adequately protected. It may also conflict with ensuring that minimum standards in the quality of care delivered to older people are met if the working conditions of carers, their access to training and supervision in private households are left unregulated. There was particular concern among home care agency managers interviewed during this research for the implications for older people in this situation:

'Having an individual of 85 years old who is then a legal employer – how do you explain to them that when they're not happy with a carer they can't tell the carer to go away in a very unpolite manner, because the carer will then go to an employment tribunal and potentially take the individual to court. If the carer injures themselves whilst doing care, we live in a more litigious society where individuals are more aware of their rights as employees. The individual injures their back. Where was the risk assessment for this?' (Manager of a home care agency in East Anglia)

The findings underline the need for better access for employers and migrant care workers to information and advice on employment rights, and for monitoring of the adherence of employers to those rights, particularly in the context of direct employment relationships between older people (or family members) and care workers, which do not fall under current regulatory systems in the care sector. They also underline the need for external 'intermediaries', such as local authorities or home care agencies, to oversee direct employment relationships, e.g. by ensuring that older people are aware of their responsibilities as employers and of the rights of the carers that they employ. In addition, there appears to be a need for other institutional means of support for migrant care workers, such as trade unions and professional associations, in representing their interests and negotiating with care homes and home care agencies as their employers.

Second, the research points to possible tensions in particular between policy aims for the 'personalization' of care for older people, by improving the responsiveness of social care providers to the needs and preferences of older people, and the rights of migrant care workers not to suffer discrimination. Migrant care workers' and employers' experiences of race discrimination towards migrant workers by older people indicate a need for adequate equalities

guidance and training for managers and care workers, and for procedures to be established in care homes and by home care agencies to ensure that the delivery of care services complies with discrimination legislation while meeting the needs of older people (which may include meeting particular language and religious needs). In addition, migrant care workers' experiences of discrimination by care workers and managers point to broader issues of concern regarding the implementation of procedures for addressing workplace discrimination in the care sector.

Third, differences in entitlements according to the immigration status of migrant care workers, including access to publicly funded social care training, appear to conflict with policy aims for the professionalization of the social care workforce through improvements in qualifications and training. Restricting access to training through immigration controls has implications not only for the positioning of migrant care workers in lower-paid, lower-skilled and lower-status positions in the care sector, but also for the quality of care delivered to older people.

Finally, the findings point to issues concerning the monitoring of different dimensions of race inequality and discrimination in the care sector and the collection of data in this context. These dimensions include differences in pay, access to training and promotions, and disciplinary procedures. Research by Hussein et al. (2009), which looked at referrals of care workers dismissed for misconduct to the Protection of Vulnerable Adults list, found that data on the ethnicity of care workers was not always recorded and therefore the extent to which workers from particular ethnic groups may be over- or under-represented among referrals could not be determined. In addition, the findings of this research raise questions concerning the extent to which data collection on the nationality and immigration status of care workers is needed, including through the NMDS-SC, in order to examine inequalities and discrimination on these grounds.

8. Future Scenarios

In this report, on the basis of the evidence we have gathered, we have explored the role, experiences and outcomes of the employment of migrant care workers in the provision of social care to older people. In this chapter, we reflect upon possible future scenarios affecting the demand for and supply of migrant care workers in the UK.

We begin by discussing the impact of population ageing on the potential future demand for migrant workers in older adult care, and consider the implications of that demand in the light of our earlier findings. To this end, we carry out projections of the workforce that will be needed to meet the future demand for care, focusing on the potential contribution of foreign born workers.

While the results of our projections suggest that the care sector is likely to continue to rely on significant numbers of migrant workers, the future demand for migrant carers will crucially depend on the extent to which alternative groups of workers will be available on the social care labour market. In section 8.2 we discuss the potential role of alternative pools of labour, reviewing the capacity of the care industry to recruit people who are unemployed, inactive or employed in other occupations.

We then reflect upon the short-term consequences of the current economic downturn. We review the limited evidence available so far and discuss the possible implications for migration trends, the employment outcomes of migrants who already work in the UK labour market, and the demand for and funding of older adult care services.

8.1 The impact of population ageing on future demand for migrant care workers

As noted in chapter 2, the UK population is expected to continue to age significantly over the next 20 years, with the proportion aged 65 years and over expected to increase from around 16 per cent to 22 per cent in 2030. Population forecasts also predict double ageing, with the number of people aged 80 years and over expected to nearly double between now and 2030 and their proportion in the overall population expected to rise to 7.5 per cent (GAD 2007). It is the magnitude and pace of population (double) ageing in the UK that raise concern for the provision of both institutional care and home care for older people.

Much of the debate around the future demand for care of older people in the UK is cost-driven (see e.g. Wanless 2006; Wittenberg et al. 2004, 2008). However, increasingly concern has

moved to workforce issues, but with limited attention to the contribution of migrant carers to the care workforce (Leeson and Harper 2006).

The concerns seem justifiable. Skills for Care, modelling future workforce scenarios based on NMDS-SC data, estimates that the adult social care workforce will need to rise by between 0.7 and 1.1 million by 2025 (up to 2.1–2.5 million) (Eborall and Griffiths 2008). As we shall see in the following, the demographic trends outweigh any reduction that may ensue from a declining incidence of need for care.

As outlined in chapter 2, the extent to which the increasing demand for care will imply the need to expand the workforce caring for older adults will depend on a number of covariates, first and most important the amount of informal care provided within the family. Projections of family care provided by children to their older parents suggest that there is likely to be a gap which will create an even higher demand for formal care (Pickard 2008), although it has been suggested that this may be mitigated by more informal care provided by spouses. New technology is also being looked to as an alternative to enable larger numbers of older people to remain in their homes and live independent lives (see section 2.4.3 above).

In the following, we shall project the number of care workers needed in care for older people on the assumption that the intensity of care needed by the older population – or, in other words, the dependency ratio between the older population and the care workforce – will remain constant over the coming decades. We construct a low, a medium and a high scenario corresponding to different contributions of foreign born carers to the workforce.

It should be underlined that these projections are **not** an attempt to make forecasts about the future. They are simply mechanical projections on the basis of specific assumptions about future trends in the number of older people, the care ratio, the need for care and the UK/foreign born mix of the workforce caring for older people. No attempt is made to incorporate policy or structural changes in respect of the provision of care for older people in the UK.

8.1.1 Methodology, assumptions and scenarios

This model produces projections for the future trends in demand for UK and foreign born care workers and nurses working with older people in the UK. It is cell-based and consists of three components. The first estimates the base year numbers of carers (care workers and nurses) working with older people – based on a combination of different data sources – and the respective dependency care ratios (the ratios of care workers and nurses caring for older people to the number of people aged 65 years and over); the second uses the official demographic projections (by age group and gender) of the older population (GAD 2007) to

estimate the number of carers required for maintaining constant dependency care ratios; the third estimates the numbers of UK and foreign born carers required on the basis of low, medium and high assumptions in relation to the contribution of the foreign born workforce. The number of foreign born carers at the beginning of the projection period is estimated by assuming the proportion of foreign born care workers (19 per cent) and nurses (35 per cent) in care for older people derived from the COMPAS survey of employers.

The three scenarios represent a form of sensitivity analysis of the demand for foreign born workforce in older adult care. Assumptions in relation to number or proportion of foreign born carers are as follows:

- *Low scenario:* the base year *number of foreign born carers* is kept constant throughout the projection period.
- *Medium scenario:* the base year *percentage of foreign born carers* is kept constant throughout the projection period.
- *High scenario:* the base year *number of UK born carers* is kept constant throughout the projection period.

Essentially, the low scenario assumes that the future additional demand for care work has to be met entirely by UK born workers; the high scenario that it has to be met entirely by foreign born workers; and the medium scenario that foreign born workers have to contribute to the expansion of the care workforce to the same extent that they are contributing at the beginning of the projection period.

The details of the methodology are fully reported in appendix 5.

8.1.2 The demand for carers and foreign born carers of older people in the UK

Overall, it is estimated that 642,000 care workers and 60,000 nurses were working in care of older people in the UK in 2006.⁷⁷ The dependency care ratios in 2006 were thus 0.0663 for care workers (i.e. 1 care worker per 15.1 older people) and 0.0062 for nurses (i.e. 1 nurse per 160.7 older people).

Based on the percentages of foreign born care workers and nurses recorded by the COMPAS survey of organizations providing care for older people (see figure 4.1), we estimated that around 122,000 care workers (19 per cent of the workforce) and 21,000 nurses (35 per cent of the workforce) were born outside the UK at the beginning of our projection period.

⁷⁷ See appendix 5 for details of how these estimates were obtained.

Table 8.1 shows the projection results. According to the projected population development for the older population aged 65 years and over and with constant care ratios as estimated in the base year, the total number of care workers (individuals) involved in older adult care is projected to increase from 642,000 in 2006 to 1,025,000 in 2030, and the total number of nurses working with older people from 60,000 to 96,000 over the same period. These growth figures are in their own right significant and demand that the policy and structural framework surrounding the recruitment and retention of carers of older people be addressed.

In addition to this overall concern, the reliance on foreign born workers and the prospect of that reliance potentially increasing makes the need to address the sustainability of the workforce caring for older people even more acute. The projections in table 8.1 reveal that varying degrees of pressure on the demand for foreign born care workers are possible. If the percentage of foreign born care workers looking after older people in the UK has to remain constant, the number of foreign born carers is projected to increase from 122,000 in 2006 to 195,000 in 2030 – an average annual growth of around 3,000 or 2.5 per cent. Although significant, the (net) number of new migrants joining the care workforce under this scenario would be smaller than the expansion of the foreign born care workforce observed over the past decade – about 90,000 in all adult care according to our estimates based on LFS estimates (see section 4.3), possibly 6,000–7,000 annually joining (and staying in) the older adult workforce. This would represent a slowdown in the short term compared with the unprecedented levels of care worker migration of the last decade, but still a considerable expansion of the foreign born workforce over a 25-year period.

If, however, the future additional demand for care work has to be met entirely by migrant workers (high scenario), the number of foreign born care workers is projected to increase to 505,000 – an average annual growth of 16,000 or 13.1 per cent, so at least double that of the past decade. Under this extreme assumption one in two care workers would be foreign born at the end of the projection period. This is, as we have seen, similar to the current situation in London.

The demand for foreign born nurses under the three scenarios is more modest in terms of numbers but not in terms of percentage growth rates – just above 500 a year, corresponding to an average annual increase of 2.5 per cent under the medium scenario, and around 1,500 a year (or an average annual increase of 7.1 per cent) under the unlikely high scenario.

TABLE 8.1: PROJECTIONS OF CARE WORKERS AND NURSES WORKING IN CARE FOR OLDER PEOPLE IN THE UK AND PROJECTIONS OF FOREIGN BORN WORKERS AMONG THESE UNDER LOW, MEDIUM AND HIGH SCENARIOS, 2006–2030

	2006	2010	2015	2020	2025	2030
Care workers						
Total (000)	642	682	772	840	923	1,025
<i>of which foreign born:</i>						
Low scenario	122	122	122	122	122	122
Medium scenario	122	130	147	160	175	195
High scenario	122	162	252	320	403	505
<i>Proportion of foreign born</i>						
Low scenario	19%	18%	16%	15%	13%	12%
Medium scenario	19%	19%	19%	19%	19%	19%
High scenario	19%	24%	33%	38%	44%	49%
Nurses						
Total (000)	60	64	72	79	87	96
<i>of which foreign born:</i>						
Low scenario	21	21	21	21	21	21
Medium scenario	21	22	25	28	30	34
High scenario	21	25	33	40	47	57
<i>Proportion of foreign born</i>						
Low scenario	35%	33%	29%	27%	24%	22%
Medium scenario	35%	35%	35%	35%	35%	35%
High scenario	35%	39%	46%	50%	55%	59%

Source: Authors' calculations

8.1.3 Discussion

The model produces projections of the future demand for UK born and foreign born care workers and nurses in care for older people in the UK under low, medium and high scenarios on a series of base assumptions. No element of prediction is intended in making these assumptions, as there is a complex set of external factors at play including local marketplace conditions, structural frameworks (campaigns to recruit and retain carers; pay and working conditions) and policy developments. Clearly, the analyses presented here are sensitive to changes in the base assumptions. This is evident from the range of projection results produced by the three scenarios of the model.

The scenario (sensitivity) analyses reveal that future demand is sensitive to the assumptions about the relative prominence of UK born and foreign born within the composition of the workforce, which in turn depends on the above-mentioned complex of external factors. The analyses would indeed also be sensitive to the assumptions about the future development of the older population, but we have decided for ease of presentation to focus solely on the principal variant of the GAD projections. Furthermore, the analyses would be sensitive to assumptions about the development of prevalence and incidence of disability (this is illustrated in appendix 5). The key and most obvious implication of this sensitivity is that there is an inherent uncertainty in the future levels of demand.

Bearing these sensitivity issues in mind, the projections of the older adult care workforce and its foreign born component do have clear policy implications. First and foremost, they raise the important issue of the sustainability of the provision of care for older people – both institutional and in the home – showing that, to keep pace with the demographic development, the older adult care workforce will need to increase in size significantly over the coming years. They also reveal that the demand for foreign born carers working with older people could increase further if long-term policy and structural developments aiming to recruit more carers born in the UK and improve retention are not implemented and successful. The extent to which the care sector will continue to rely on migrant workers crucially depends on the size and quality of this investment.

Obviously, our low and high scenarios represent extreme cases. However, it has to be stressed that even the medium scenario, although more realistic, does not correspond to a likely development intrinsic in the ongoing trends. Indeed, the case is rather the opposite: i.e. the assumption that the proportion of foreign born workers will remain constant over the next two decades implies a significant diversion from current trends, which have seen an increase of the proportion of migrants in the care workforce by 1 per cent a year over the last decade (from 8 per cent in 1998 to 18 per cent in 2008 for the overall adult care workforce). For the coming years, keeping the proportion of foreign born in the older adult care workforce constant would approximately correspond to halving the reliance on the net flows of migrants – either recruited abroad or already in the UK – into the sector. Again, this is a rather ambitious policy target for the care sector which would require significant structural reforms.

Finally, it is useful to link these projections with the earlier discussions on the demand and preferences for care in old age, factoring into the overall demand equation changes in people's expectations and preferences as well as changing family structures. In southern European countries a pattern of care for older people in the home employing irregularly (female) migrant carers has emerged as a main response to changing family roles and the inadequacy of formal care provision (Simonazzi 2009). Although there is no data showing what is the extent of

irregular employment in the UK care sector, qualitative evidence suggests that this may happen (see chapter 5). Therefore, the preference for care provided within the home and the difficulty of regulating employment relationships in private households – especially if paralleled by a lack of legal entry routes for low skilled migrant care workers – raise concerns that the future increase of the demand for care may foster the development of a ‘grey area’ of irregular migrant labour within private households also in the UK.

8.2 Alternative sources of labour supply

As illustrated throughout this report, large-scale employment of migrant care workers has emerged as – or is perceived to be – the principal response to the staff shortages in the care sector. Particularly in the south of the country, extensive reliance on the migrant workforce has become essential to many organizations providing care for older people. While a number of factors may have contributed to this, the mismatch between labour demand and domestic supply can be ascribed mainly to structural features of the social care sector, namely the poor wages and working conditions available in the labour market.

In the previous section we showed that current and continuing demographic trends imply that a significant expansion of the care sector workforce will be essential to meet the care needs of future cohorts of older people – even assuming no improvement in the availability/intensity of care services. We argued that this significant growth of the care workforce will be hard to achieve without recruiting migrant workers, although the need to rely on the migrant workforce will crucially depend on the extent to which alternative groups of workers will be available on the social care labour market. In this section, we discuss the potential for the care sector to rely on different pools of labour. Our aim is not to predict the extent to which the care sector will be able to increase its attractiveness for the domestic labour force, but rather to review what factors can underlie different trends. Our discussion will also build on some evidence on the responsiveness of the domestic workforce to recent labour market trends.

8.2.1 Alternative solutions to the labour shortages in the care sector

In theory, employing migrant workers is only one of the options employers may choose to cope with a shortage in the locally available workforce. Some of the solutions available to employers in other sectors are not available or offer less scope for intervention to employers in social care – e.g. businesses cannot relocate to countries where labour costs are lower and can only to a certain extent increase the investment in labour-saving technology. However, social care providers can, at least in principle, respond to perceived staff shortages by increasing wages

and improving working conditions so as to make care jobs more attractive to the domestic workforce. Whether or not this is a practicable route to solving their recruitment problems ultimately depends on the cost of this strategy relative to the 'cost' – understood in a wide sense – of hiring migrant workers.

Employers in labour-intensive industries may be reluctant to increase wages and non-wage costs because of concerns about their competitiveness, and, in the most extreme cases, for fear of being priced out of the market (Anderson and Ruhs 2008). Therefore, the availability of low-paid, flexible migrant labour can shape the preferences of employers by offering them a better option than increasing the running costs of their business. This is especially true in a sector like social care, where labour costs make up around half the cost of providing home care and between half and two-thirds of the running cost of care homes (Wanless 2006).

However, in some sectors there are also important structural factors falling outside the scope of intervention by individual employers that make it difficult to pursue alternatives to the recruitment of migrant workers (Anderson and Ruhs 2008). As highlighted earlier in this report, this is a critical issue in social care, where the upward mobility of pay is constrained by the limited resources provided by the public sector – which is the main purchaser of care services (accounting for about two-thirds of the total) and has to balance the allocation of its funding between different services – and by regulations setting requirements about minimum staffing. Therefore, removing this barrier would ultimately require a higher tax burden and/or a reorganization of the structure and regulation of the care sector.

Under present conditions, it is not difficult to understand why the reliance on migrant workers has relatively quickly become a structural feature of the care sector. While there is no consistent evidence of a negative effect of the employment of migrants on the wages and employment levels of the UK born workforce (Lemos and Portes 2008), the mutual adjustment of labour demand and supply can trigger 'path dependencies' in the employment of migrants (Anderson and Ruhs 2008), making it difficult and costly for employers whose workforces already include a substantial share of migrants to switch to alternative strategies. That is, employing migrant labour to fill vacancies in the short term, while possibly crucial to ensure the survival of businesses, may have the unintended long-term consequence of giving momentum to the factors that discourage the supply of domestic workers – not necessarily lower wages but, for instance, no investment in new technologies or the upskilling of the workforce and, most importantly, a stronger perception of the low status of the job.

Concerns about the possible increase of dependence on migrant workers in the long term were indeed central to the assessments underlying the Migration Advisory Committee (MAC) shortage occupation list. Interestingly enough, the MAC, while recognizing that wages in the social care labour market are highly dependent on the allocation of public funding to the sector,

did not consider this structural constraint as a factor able to prevent wages from rising in the long term up to the levels ensuring a domestic labour supply to match demand.⁷⁸

Whether the conditions for a shift away from the dependence on migrant workers can exist in the social care labour market depends not only on employers' attitudes and practices but also on domestic workers' expectation, i.e. on the propensity of different groups of people who are currently unemployed, inactive or employed in other sectors to apply for care jobs. Reluctance to engage in certain types of work may restrict flexibility of the labour supply. Therefore, assuming that the employers could afford to offer better wages and working conditions for the care jobs, a critical question is how different segments of the working age population would react to these improvements.

While we can reasonably expect that rising wages would trigger an increase in domestic labour supply, the extent of this increase is very uncertain. In economic terms, the elasticity of labour supply with respect to wages differs across groups of individuals, sectors and occupations, and depends on a number of factors. Among them it is important to remember the following:

- The trade-off between employment and public benefits, i.e. the fact that unemployed or inactive people may have to give up the benefits they are receiving if they start working – or assume they have to.⁷⁹ The lack of flexibility of the benefits system has been recognized as a disincentive to taking up low-paid jobs in various sectors of the UK economy (Anderson and Ruhs 2008).
- The skills needed to perform the job, i.e. the fact that in some sectors and occupations it may take significant time for domestic labour supply to respond to increases in wages because, for example, domestic workers lack the required skills and need to be trained.
- Other costs associated with taking up a job, the most obvious being the reduction of workers' time to look after their own families. For people who have children or older relatives in need of care, there is very little incentive to take up a paid care job which is likely to be demanding, and professionally and socially unrewarding. The material costs of paying someone else to look after their own family, as well as the psychological cost of being away from them, hardly weight the trade-off between paid and unpaid care in favour of the former.

⁷⁸ The MAC report states: 'In the long run, however, even in the public sector, we would expect the relative wage in shortage occupations to rise. This implies that the cost of supplying these services will increase. Although we recognise that many public budgets may be fixed in the short term, in the longer run it would not be sensible to supply these important services on the basis of low-paid immigrant labour' (MAC 2008a: 138).

⁷⁹ For example, unemployed people who take a job do not lose their housing benefit but think that they will.

A comprehensive analysis of the mechanisms by which the potential alternative sources of labour supply adjust their preferences according to the conditions available on the social care labour market is beyond the scope of this report. Nevertheless, a quick overview of empirical data showing the recent trends in the employment of the domestic labour force helps shed more light on the conditions which have accompanied the significant increase in the reliance of the care sector on migrant workers.

8.2.2 The participation of the domestic workforce in the care sector: recent trends

As shown in chapter 2, in the past few years there has been a significant increase in care workers' real wages – nearly double the increase of the overall income in the UK – leading to a widening of the pay salary differentials between care jobs and other low-paid occupations such as retail sales or cleaning. Has this improvement of pay levels encouraged more inactive and unemployed to take up work opportunities in the care sector? Has the care sector absorbed part of the workforce from other low-paid occupations where pay conditions have become comparatively less advantageous?

A definite answer to these questions would require a rigorous analysis of the causal relationship between wage and employment trends which is beyond the scope of this report. However, some idea of the response of different workforce groups to the recent wage increase can be drawn from the observation of occupation-specific unemployment trends and changes of employment status of the workforce participating in the social care labour market.

The following analysis, based on Labour Force Survey (LFS) data, refers to the overall care workforce and not just to those working with older people. LFS data can provide a measure of occupation-specific unemployment rates based on the information about the last job carried out by the current stock of unemployed and inactive people.⁸⁰

Table 8.2 sets out trends from 2003 to 2008 in the workforce delivering personal services in health and social care,⁸¹ along with those of unemployed and inactive people available to

⁸⁰ The unemployment rates by previous occupation are only a rough indicator of the employment opportunities of the people in that occupation because they are based on the last job performed, while obviously unemployed people can take up jobs in other sectors and occupations.

⁸¹ This is based on the variable *sc2klmn* recording the occupation group (SOC 3-digit) in the last job of all respondents who were out of work in the reference week but have worked in the past eight years. This means data were available only for the broader occupational category *Healthcare and related personal services* (SOC 611) – which includes nursing auxiliaries – and not for the more specific category *Care assistants and home carers* (SOC 6115), which we have referred to throughout this report. Data on current employment suggests that the latter category accounts for about 70% of the broader occupational group.

work⁸² who were employed in the same occupation in their previous job. In order to focus on the long-established workforce, migrants who entered the UK in the five-year period preceding the corresponding LFS wave have been excluded from the analysis.

TABLE 8.2: EMPLOYMENT AND UNEMPLOYMENT OF LONG-TERM RESIDENT WORKERS^a IN HEALTHCARE AND RELATED PERSONAL SERVICES (SOC 611), 2003–2008

Year	Employed	Unemployed ^b		
	(000) (A)	(000) (B)	% of all unemployed	rate B/(A+B)
2003	855	78	4.0%	8.4%
2004	874	78	4.3%	8.2%
2005	867	81	4.3%	8.6%
2006	905	86	4.3%	8.6%
2007	903	84	4.2%	8.5%
2008	960	90	4.4%	8.6%

^a UK born workers + migrant workers who have been living in the UK for 5 years or more

^b unemployed and inactive people available to work who were employed in Healthcare and Related Personal Services one year before

Source: Authors' elaboration of LFS data, Apr-Jun data, various years

As illustrated in chapter 4, the domestic workforce employed in direct care roles has increased in recent years – i.e. the expansion of the workforce in the sector has not occurred just because of the employment of overseas workers. However, the estimated number of unemployed whose last job was in health and social care related services has also increased at a similar rate (+15% between 2003 and 2008). The expansion of both the employed and unemployed workforce suggests that there has been an increase in the *participation* of the domestic workforce in the sector: i.e. more people have been available to work in social care, and a number of them actually took up a job. However, this was not accompanied by a relative increase in the *probability of finding a job* in the sector for the domestic labour force. This is confirmed by the fact that neither the proportion of all unemployed whose last job was in social care nor the estimated occupation-specific unemployment rates for this group varied significantly over the observed period. In other words, more long-term resident workers started to look for a job in social care, but not all of them could actually get a job – the additional supply was not entirely absorbed by the labour market.

⁸² Based on the reported economic activity (LFS variables *inecac05*; *inecacr* before 2005) we excluded from the analysis inactive people who would not like to work.

However, the comparison between the occupation-specific unemployment rates in healthcare and related personal services and those of other major low-paid occupational categories (figure 8.1) shows that the probability of remaining out of employment has been significantly lower in care work than in other low-paid occupations – though still higher than the overall unemployment rate – and less exposed to fluctuations than, for example, the risk of unemployment of people working in the retail sector or in other lesser skilled personal service occupations.

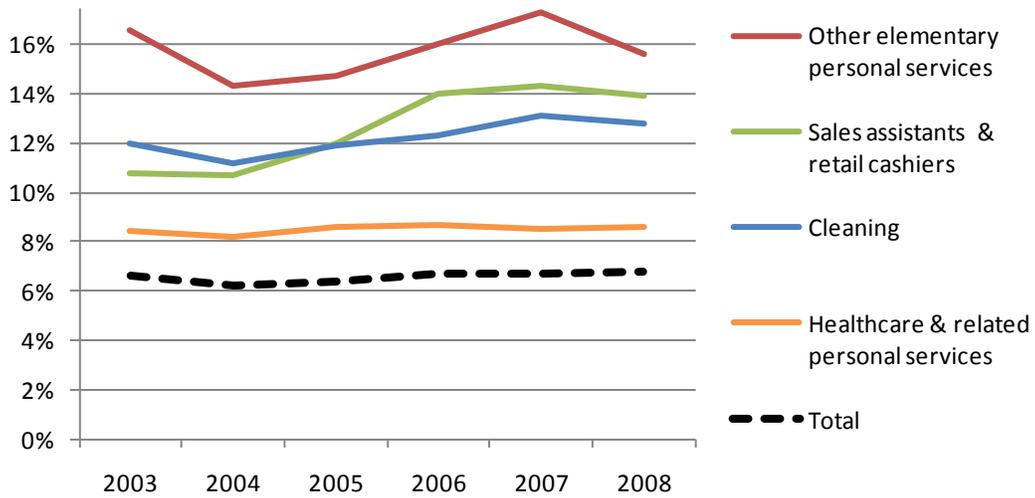
A better understanding of the involvement in care work of different segments of the potential labour supply is provided by the breakdown of workers who join and leave the direct care workforce by ‘origin’ and ‘destination’ of the flows – i.e. whether people move to or come from inactivity, unemployment or another occupation. Figure 8.2 represents the breakdown by previous employment status of the net inflows of workers into care occupations (i.e. those who joined minus those who left) during the year preceding the April–June 2008 LFS quarter. While these estimates (in brackets) are likely to underestimate the actual extent of the net flows,⁸³ they provide rather clear indications that:

- All workforce categories have contributed to the growth of the care workforce, i.e. the number of people who have moved into care jobs from other occupations, unemployment or different types of inactivity was higher than the number of care workers leaving the occupation moving to any of the above occupational statuses.
- In absolute terms, the largest inflows of workers shifting to care jobs were previously working in other occupations, studying or looking for a job. Former family carers and other inactive people starting to work as care workers in the last year have contributed relatively less to the care workforce expansion. However, the additional supply from each of these domestic sources of labour was probably lower than the net annual inflow of migrant care workers over the same period, which, based on our survey, can be estimated at about 15,000.⁸⁴

⁸³ There is a high proportion of missing cases (11%) for the LFS variable on the occupation one year before the survey (*soc2ko*). Considering also the systematic under-coverage of the care sector by the LFS, the actual magnitude of the net inflows of workers into care can easily be assumed to be 20–30% higher than the estimates reported in the graph.

⁸⁴ As shown in chapter 4, migrant workers accounted for 28% of the care workforce hired in the past year by the surveyed organizations. Applying this proportion to the LFS estimations – which do not include migrant workers who have entered the UK in the last 6 months – we obtain a figure of about 15,000. This is consistent with the order of magnitude of the net inflows for the previous years (about 17,000 in 2006 and 12,000 in 2007).

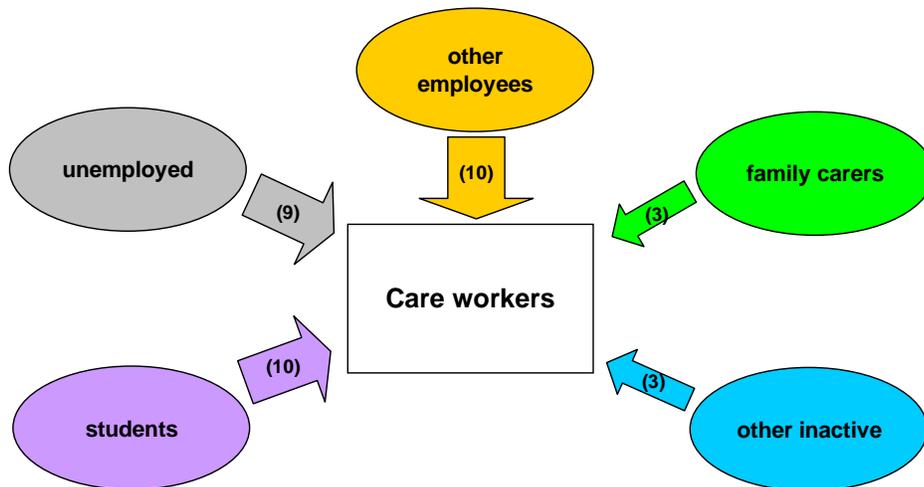
FIGURE 8.1: OCCUPATION-SPECIFIC UNEMPLOYMENT RATE^a FOR SELECTED OCCUPATIONAL CATEGORIES (3-DIGIT SOC CODES), 2003–2008



^a Including the inactive working age population available to work (but not seeking work) or who would like to work.

Source: Authors' elaboration of the LFS data, April–June, various years.

FIGURE 8.2: NET ANNUAL INFLOWS OF WORKERS INTO CARE JOBS BY PREVIOUS EMPLOYMENT STATUS, 2007/8 (000)



Source: Authors' estimates based on LFS data (April–June 2008).

A rather different picture emerges when we move from absolute measures of flows to the probabilities of the different groups taking up jobs as care workers. Figure 8.3, representing the proportions of those moving to employment from unemployment or economic inactivity or changing occupation have chosen a care job, shows that, compared with the other sub-groups, previously unemployed and family carers have by far the highest chances of starting work as care workers. In substance, this comparison suggests that the choice to take up care work mainly reflects the highly gendered structure of the occupation, the lack of alternatives – people who are already employed in other occupations are not attracted by the care sector – and the relatively lower level of formal qualifications needed to work in social care (only 1.5 per cent of former students moving to employment started working as carers).⁸⁵

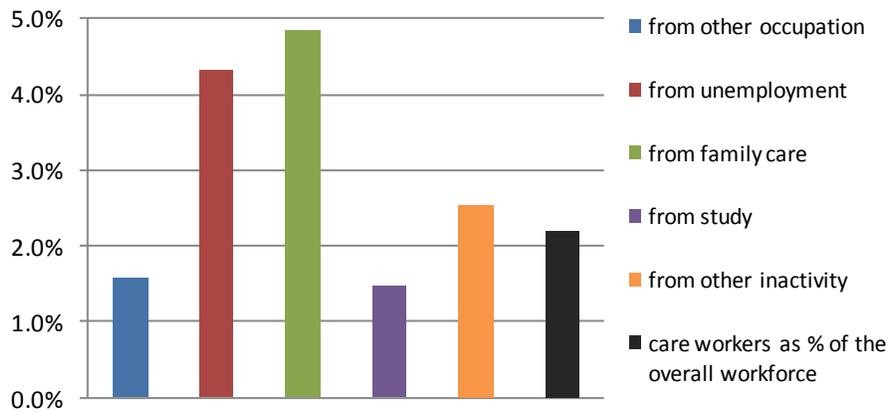
In summary, the reviewed evidence on the potential contribution of various pools of labour supply to the domestic direct care workforce provides a mixed picture. It is clear that the recent expansion of the care workforce has occurred as a result of increased participation in the social care labour market of individuals who were previously inactive, unemployed or employed in other occupations – along with significant recruitment of migrant workers. This result is in line with expectations, given the rising number of vacancies in the sector as well as the significant increase in the pay available to care workers.

However, evidence suggests that the domestic labour supply has responded only to some extent to the increasing work opportunities in the sector and that its response to the wage increase has been limited. There has been no reduction of the risk of unemployment for the domestic workforce engaged in the sector, despite a higher number of hard-to-fill vacancies (see also next section).

As we might expect, the propensity to take up direct care jobs has been relatively higher only among family carers and unemployed individuals, reflecting the still very low average wage level (below £6 an hour in residential and nursing homes in the first semester of 2008: see section 2.3.3), the highly gendered structure of the social care labour market and the lack of other suitable opportunities. This suggests a decision-making process driven more by constraints than by freedom of choice and the attractiveness of the sector.

⁸⁵ This result of course embeds the relatively low probability of being enrolled in training in social care compared to other disciplines.

FIGURE 8.3: PROPORTION OF WORKERS WHO HAVE TAKEN UP CARE JOBS IN THE LAST YEAR AMONG ALL WORKERS WHO HAVE MOVED TO EMPLOYMENT OR CHANGED OCCUPATION, BY PREVIOUS EMPLOYMENT STATUS, 2007/8



Source: Authors' elaboration of the LFS data (April–June 2008).

8.3 The potential impact of the economic downturn

In 2008 the world economy entered the most serious period of hardship since the 1973 oil shock. Though driven by the crisis in the finance sector, the downturn soon had grave consequences for the real economy, with a contraction of production and employment in most advanced economies.

The UK is no exception. Official estimates⁸⁶ show that the country's economy is in recession, with a fall in real gross domestic product of 2.4 per cent in the first three months of 2009 after a 1.8 per cent drop in the previous quarter. According to International Monetary Fund forecasts, the prospects for the UK economy are even gloomier than those for other western countries: the IMF predicts that the UK economy will contract by 2.8 per cent in 2009, a steeper decline than the US (predicted to shrink by 1.6 per cent) and the euro area (by 2 per cent).

Thousands of job cuts have been announced across all sectors of the UK economy. Unemployment reached 2.2 million between February and April 2009, up 255,000 from the previous three months and 622,000 from one year earlier. Trends in the number of vacancies are consistent. The latest figures on Jobcentre Plus notified vacancies show that there were 213,000 live unfilled job vacancies in April 2009, down 172,000 (45 per cent) from April of the previous year.

⁸⁶ Figures referred to in this section are drawn from the Office for National Statistics' website.

8.3.1 Migration, unemployment and return

The repercussions of the current economic downturn on migration and the migrant workforce overall are not easy to assess. It is reasonable to assume that the crisis affects the number and characteristics of new arrivals, the employment opportunities of those who are already in the country, and whether they decide to stay in the UK or return to their countries of origin (or indeed to migrate elsewhere). However, little anecdotal evidence on the ongoing trends is available so far. Also, the impact of the recession will ultimately depend on its magnitude and length, with a more severe and longer recession potentially leading to major changes in admission policies. Bearing in mind this great amount of uncertainty, it is possible to make some conjectures on the possible consequences of the downturn for new and settled migrants.

In terms of inflows, different categories of migrants are likely to be affected in different ways by the downturn. Economic migrants – namely people entering the country on Tier 1 and Tier 2 of the points-based system and the vast majority of EU nationals from the new member states – are likely to be most responsive to the economic cycle. For example, migrants on Tier 2 (the former work permit holders) are permitted to enter the country only if they have a job offer for a position unfilled by EEA workers, which may make this inflow sensitive to poorer employment opportunities in certain sectors. Although not subject to any visa process, the mainly labour-motivated migration of A8 nationals also seems likely to decline as a result of the decreasing economic differentials between Britain and their home countries. In other words, fewer opportunities in key sectors where A8 workers found employment (e.g. construction and hospitality) and the falling exchange rate of the British pound may have reduced the incentives for the new EU citizens to move to the UK – although adverse economic trends in their countries of origin have also reduced employment opportunities at home.

Other types of migration flows, such as migration for family and humanitarian reasons, are less likely to be affected by the economic downturn. Even if such migrants do choose to work in the UK, their decisions are likely to be driven to a large extent by non-economic factors (MPI/EHRC 2008; Papademetriou and Terrazas 2009s). However, there is a potential for the recession to create or exacerbate humanitarian crises, which could trigger larger flows of asylum seekers.

As far as international students are concerned, contrasting effects of the recession may affect their migration decisions. On the one hand the reduced value of individuals' savings in sending countries may mean less money to be invested in an overseas education,⁸⁷ but on the other there may be greater incentive to choose UK educational institutions for international students whose currencies have appreciated against sterling.

⁸⁷ For example, the 1997 Asian credit crisis decimated flows of Malaysian students to the UK and other high-income countries, including Australia (Hawthorne 2008, cited in MPI/EHRC 2008).

A key issue is the impact of the downturn for migrant workers already in the UK. The consequences for them may be particularly serious because of their over-representation in low-skilled occupations that are typically hit hardest during economic slowdowns. For example, many job losses over the past months have occurred or been announced in manufacturing, construction and retail, all sectors employing large proportions of migrants. Recent migrants can also be the first workers to lose their jobs, either because they are on shorter employment contracts (i.e. have less secure contractual conditions) or because employers may consider them 'less productive', for example owing to language barriers. Evidence from other countries shows that migrant workers may be more exposed than the native born workforce to the risk of unemployment (Papademetriou and Terrazas 2009; OECD 2009).

Since many recent migrants are ineligible for welfare benefits, they may suffer from particular hardship during the recession. Recently arrived migrants are more likely to have no savings or family support and to lack the skills for self-employment, thus facing a higher risk of falling into poverty.

On the other hand, migrant workers might be able to adjust more quickly to labour market changes. Recent migrants are typically more mobile than the long-term resident workforce. They are less likely than the domestic workforce to be tied to a particular area by family and social networks, and ineligibility for benefits increases the cost of being unemployed. Therefore they may be prepared to move to other regions or take up jobs for which the domestic supply is scarcer (MPI/EHRC 2008).

One response of migrant workers to the poorer employment opportunities in the UK may be to return home. A number of factors affect an immigrant's propensity to leave the country during a downturn, including personal circumstances, migration plans, opportunities at home, the cost of return, and opportunities to come back to the UK if they do leave (MPI/EHRC 2008). Historically, return migration flows have corresponded more with developments in countries of origin,⁸⁸ and with the ease of circulation, than with economic conditions in receiving countries (Papademetriou and Terrazas 2009). The high return rates of A8 nationals in 2007 and 2008 can be understood within this context. In contrast, policy measures to encourage return have in the past had very little success, while the restrictive immigration reforms contextually implemented had the unintended consequence of stabilizing the 'temporary' migrant population (Pastore 2008).

⁸⁸ Major examples of return migration, e.g. to Ireland, Spain, Portugal or Greece, occurred with the significant reduction of the development gap previously existing between the sending and receiving economies (Papademetriou and Terrazas 2009).

8.3.2 Possible implications of the economic downturn for the social care workforce

The demand for older adult care is mainly shaped by health and demographic factors, i.e. it is driven more by long-term trends than by short-term fluctuations related to the economic cycle. There are, however, both financial and socio-economic consequences of the recession which are likely to affect the demand for care services in the short run.

Historically, in periods of economic slowdown local authorities see higher levels of demand for services such as benefits, social care and social housing (Audit Commission 2008). Demand for public services for older people is likely to increase for a number of reasons. The contraction of household purchasing power is likely to reduce households' ability to pay for care services needed by their older members, and more families may become eligible for public services or direct payments. A long period of economic hardship may lead to higher rates of family breakdown and exacerbate health conditions of the more marginalized older population, thus increasing the demand for residential places for older people. According to the Audit Commission's review of the impact of the economic downturn on local government finances, only a quarter of chief finance officers had observed additional demand for elderly care in 2008, but over half are expecting demand to increase in 2009/10 (Audit Commission 2008). Given the significant budget constraints under which many local authorities are already operating, the economic downturn could put even more strain on their finances, with implications for their capacity to meet the needs of an increasing number of deprived households. One possible consequence of the increasing tension between the demand for public support and the limited capacity to respond to older people's needs is that more families may have no choice but to take care of their older relatives, thus increasing the supply of family care and providing some relief for local government finances.

Implications for private care providers may also be significant. The increasing pressure on the local government budget may also affect the reallocation of resources to private organizations contracted to provide residential and home care services to the older population. Households' capacity to purchase private residential care services is likely to be reduced by the crisis in the housing market,⁸⁹ for many older people sell or let their houses when they move to care homes. Private care enterprises may be hit hard by the credit crunch: having borrowed significant amounts of money to set up in business, they are now finding it difficult to refinance these loans in the current situation of the banking industry.⁹⁰

⁸⁹ See Stephen Burke's opinion, reported in 'How the financial crisis will affect social care – experts give their view', *Guardian* online, 8 Oct. 2008, <http://www.guardian.co.uk/society/2008/oct/08/credit.crunch.social.care>.

⁹⁰ See Gordon Lishman's opinion, reported in 'How the financial crisis will affect social care – experts give their view', *Guardian* online, 8 Oct. 2008, <http://www.guardian.co.uk/society/2008/oct/08/credit.crunch.social.care>.

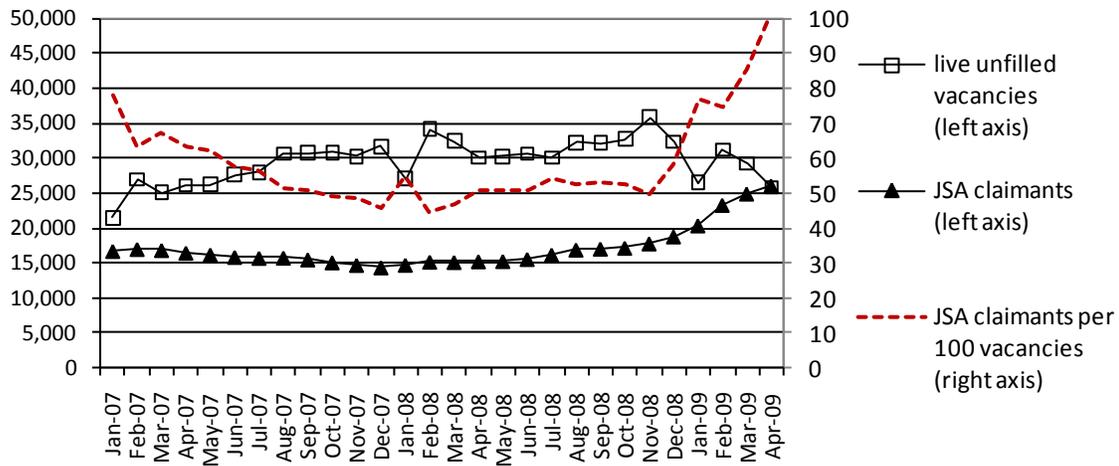
On the whole, these potential implications of the economic downturn point more to structural changes in the demand for care services than to a sizeable impact on the overall volume of demand. The most plausible effect seems to be an increasing burden on public services, reflecting the reduced ability of households to purchase care for their older members privately. The relative stability of the demand compared to other industries suggests also that employment in the care sector may be affected to a more limited extent by the recession. However, some negative impact on employment opportunities of care workers is still possible because of certain of the effects mentioned above – e.g. the rationing of public resources and lesser access to credit – and because of employers’ fear for the prospects of their businesses. For example, employers may be reluctant to hire new care workers and try to rely more intensively on workers who have been working longer with their organization, e.g. cutting part-time jobs. Retention may also increase because workers have fewer opportunities to find jobs in other sectors.

One possible scenario is that the care sector may be more able to rely on the domestic labour supply (including migrants already in the UK) than in the recent past. In other words, job losses in other sectors may spur larger numbers of unemployed – as well as workers exposed to higher risks of redundancy – to apply for jobs in social care. On the other hand, some of the new migrants who have significantly contributed to the expansion of the social care workforce, such as EU nationals and students, may come in smaller numbers if the recession continues.

The above discussion is rather speculative. Some information on actual trends is available from official statistics on vacancies and claimants of unemployment benefits in the sector (figure 8.4). However, caution is necessary in interpreting these monthly time series because the observation period is not long enough to capture the overall impact of the economic downturn. Also, it is not possible to isolate the effects of the recession from other possible changes resulting from unrelated processes.

Figure 8.4 shows the stock of live unfilled vacancies of care workers held by Jobcentre Plus since the beginning of 2007 against the number of claimants of JSA who seek employment as care workers, as well as the ratio of the unemployed to the available vacancies which is a proxy measure of the mismatch between labour demand and supply – increasing/decreasing values of the ratio indicating that labour supply is rising/shrinking relative to demand.

FIGURE 8.4: LIVE UNFILLED VACANCIES HANDLED BY JOBCENTRES AND JOBSEEKERS' ALLOWANCE CLAIMANTS (CARE ASSISTANTS AND HOME CARERS: SOC 6115), JANUARY 2007–APRIL 2009



Source: ONS, Nomis labour market statistics (accessed 16 May 2009).

The rising number of JSA claimants from the second half of 2008 seems to suggest some impact of the economic downturn on unemployment of care workers. The rise in unemployment becomes steeper at the beginning of 2009. The number of unfilled vacancies handled by Jobcentres continued to grow during the first months of the recession, and started falling only from December 2008. It is currently at its lowest level since 2007, while unemployment is at its highest. Therefore, the ratio of unemployed people to jobs available in the sector has boomed since the beginning of 2009. In April 2009, for the first time over the observed period, there were more JSA claimants seeking care work than vacancies in the sector, despite the fact that vacancies for care workers have fallen at a much lower rate than average (MAC 2009b), and the vacancy-to-unemployment ratio for care workers remains much higher than for the overall workforce: there are currently six people unemployed per live unfilled vacancy in Britain.

We collected qualitative evidence on the impact of the economic downturn from employers in February and March 2009. Most employers had not experienced major changes until then. None of them said they were experiencing or expecting redundancies. However, some suggested they had reduced overtime work. Interestingly, quite a few of them who were recruiting reported that they were experiencing a better turnout from UK born applicants. While some seemed moderately hopeful that this might have improved their recruitment and retention capacity, others were very doubtful about the suitability of these candidates.

'We're having more local applicants applying to us now, because they are unemployed, but they won't be permanent workers, they're just people who need to earn money because they have lost their jobs. They're not going to stay in it for a career... not a long-term prospect for us really.' (Home care provider based in East Anglia)

'If anything actually I'd probably have more applicants... but I would have to say that quite a few of them are completely inappropriate responses as well.' (Manager of a nursing home in the South East)

To conclude, there is so far only limited evidence on the consequences of the economic downturn for the care workforce. The relative stability of the demand for care – in comparison with other goods and services – suggests that the social care workforce should be less exposed to the economic slowdown than workers in other less-skilled occupations. Potentially, the domestic supply of workers available to take up care jobs may increase as a result of redundancies in other sectors and the reduction in household income pushing more inactive people into the labour market, but the availability of the care sector to employ this additional workforce cannot be taken for granted because candidates with no experience of care work and perceived by employers to have no career prospects in the sector may be considered unsuitable. A long-lasting recession could also involve further budget constraints for the private sector, because of the possible rationing of public funding as well as greater difficulties in accessing credit. As far as new migrants are concerned, their availability may decline in the near future, especially because of smaller inflows of A8 nationals who have represented a primary source of labour in recent years. Given the high degree of uncertainty around these processes and the possible adjustments, collection of new evidence in the coming months will be extremely useful.

8.4 Conclusion

Far from attempting to predict the future, this chapter has tried to shed some light on the possible factors shaping demand for and supply of migrant workers in social care, in both the long and the short term. In the long term, demographic trends are likely to play a fundamental role. Despite some inherent uncertainty in terms of health and disability of the older population, our simple projections show that to keep pace with demographic developments the workforce in older adult care will need to increase in size significantly over the coming years. We conclude that unless significant policy and structural developments boost the supply of UK born workers by making care jobs more attractive and rewarding, the demand for foreign born care workers and nurses working with older people could also increase significantly. In the light

of the social changes and welfare restructuring currently under way in the UK market for care – e.g. older people’s preferences increasingly shifting to home care, changing family structures, and the development of cash-for-care schemes – we argue that there is potential risk of (further) development of a grey area of older adult care in the home employing (female) migrant carers – an already widespread phenomenon in other European countries.

While the results of our projections suggest that the care sector is likely to continue to rely on significant numbers of migrant workers, the actual future demand for migrant workers will crucially depend on the extent to which alternative groups of workers become available on the social care labour market. The reviewed evidence on the contribution of the different potential pools of labour supply to the domestic direct care workforce provides a mixed picture. It is clear that the recent expansion of the care workforce has occurred as a result of increased participation in the social care labour market of individuals who were previously inactive, unemployed or employed in other occupations – along with the significant recruitment of migrant workers. This result is in line with expectations, given the rising number of vacancies in the sector (at least until the end of 2008) and the significant increase in the wages available to care workers. However, evidence suggests that the domestic labour supply has responded to only a limited extent to the increasing work opportunities in the sector and to the increase in pay. There has been no reduction in the risk of unemployment in the domestic workforce engaged in the sector, despite a higher number of hard-to-fill vacancies. Unsurprisingly, the propensity to take up care jobs has been relatively higher only among family carers and unemployed individuals, rather than among students entering the labour market or people employed in other occupations, which suggests that the attractiveness of care work has not increased much despite a quite significant increase in pay (albeit from a low base) – both in absolute terms and relative to other low-paid occupations.

In the short term, the repercussions of the current economic downturn on migration and the migrant workforce are hard to predict. It is reasonable to assume that the crisis will affect the number and characteristics of the new arrivals, the employment opportunities of those who are already in the country, and decisions on whether to stay in the UK or returning home. There is so far only limited evidence on the consequences of the economic downturn for the care workforce. The relative stability of the demand for care – in comparison with other goods and services – suggests that the social care workforce should be less exposed to the economic slowdown than workers in other less- skilled occupations. Potentially, the domestic supply of workers available to take up care jobs may increase as a result of redundancies in other sectors and more inactive people being pushed into the labour market as a result of reductions in household income, but the availability of the care sector to employ this additional workforce can not be taken for granted because candidates with no experience of care work and no perceived career prospects in the sector may be considered unsuitable. The availability of new

migrants may decline in the near future, especially because of smaller inflows of A8 nationals who have represented a primary source of labour in recent years. Given the high degree of uncertainty around these processes and the possible adjustments, collection of new evidence over the upcoming months would be timely.

9. Conclusions and Policy Recommendations

This report has addressed the current and potential future impact of an ageing population on the demand for migrant workers to provide social care for older people. It has drawn on survey and interview data and analyses of national data sources to consider the extent to which migrants (people born abroad) may be needed to meet demand for care services. It has also, on the basis of evidence of current experiences within the sector, considered the potential implications for employers, older people, their families and migrant workers. Focusing on the UK, it reports the findings of one of four country studies conducted between spring 2007 and spring 2009 in the UK, Ireland, the USA and Canada: the other three separate reports, and an overview comparative report, will also be published this year.

In this final chapter we summarize our findings and consider the potential implications for migration and social care policy, on which there are currently keen – but too often separate – debates. Our overarching conclusion is that the solution to the challenges we have identified lies, fundamentally, in the social care system. The current extensive reliance on migrant workers in the provision of care for older people is not the solution to the shortage of staff in the care sector but a symptom of the sector's inability to recruit sufficient labour to meet its needs at the conditions currently prevailing on the care labour market. Nevertheless we find that in practice migrant care workers are likely to continue to play a central part in the future care system, and the implications of their contribution must therefore be addressed – not ignored – in the consideration of future immigration and social care policies. In this and other respects the findings and conclusions of the parallel US, Canadian and Irish studies bear striking resemblance to our own; not least the conclusions of the Canadian report that 'the relative invisibility of the conditions of eldercare is mirrored in the work conditions of immigrant care workers' and of the Irish report that 'it is impossible to separate the fate of migrant care workers from that of older people and their families'.⁹¹ Reform in the social care and immigration systems must proceed in parallel if the challenges we have identified for older people and for migrant workers are to be resolved.

⁹¹ Bourgeault et al. (2009) and O'Shea and Walsh (2009).

9.1 Research questions and method

The research addressed four questions:

- the factors influencing demand in an ageing society for care workers – and in particular migrant care workers – in the provision of care for older people;
- the experiences of migrant workers, their employers and older people in different care settings, including the direct employment of migrant care workers in private households;
- the implications of the employment of migrant workers for the working conditions and career prospects of the migrants and for the quality of care for older people;
- the implications of these findings for the future social care of older people and for migration policy and practice.

There were five components to the investigation, set out in the introduction and in the appendices:

- analysis of existing national data sources on the social care workforce in the UK, largely based on the Labour Force Survey and focusing on the migrant direct care workforce;
- a postal and on-line survey, between January and June 2008, of 557 employers of care workers, including residential and nursing homes and home care agencies, followed by in-depth interviews by telephone with 30 participants in the survey;
- in-depth, face-to-face interviews, between June and December 2007, with 56 migrant workers employed by residential or nursing homes, home care agencies, other agencies supplying care workers, or directly by older people or their families;
- five focus group discussions, between December 2007 and March 2008, with 30 older people, including current users of care provision and prospective care users (members of community groups for older people); and
- projections of potential future demand for migrant care workers in older adult care.

9.2 Summary of findings

Chapter 2 provided necessary background information on the provision of social care and on recent policy developments and debates relevant to our research questions. Informal care by

families and friends remains the dominant form of provision, and the extent to which this will continue is relevant to the future demand for paid services. Although most formal care is provided by the private and voluntary sectors, it is to a great extent publicly funded and hence highly affected by public expenditure constraints. Social care services have been the focus of ongoing reforms including a shift towards home care, increasing procurement of care services from independent providers, and targeting of public expenditure on those older adults with greatest needs.

Evidence shows that nearly half a million older people have some shortfall in their care provision. The ageing population, and in particular the rising number of those over 80, is one key factor in the expected growth in the (predominantly female) social care workforce from the current 1.5 million to a possible 2.5 million by 2025. The future structure and funding of care provision are under review. The inability of public funding to keep pace with cost increases in the private care sector, for instance following increases in the National Minimum Wage, is one significant concern. In 2007/8 the average unit cost of 'in-house' local authority homecare was £22.30 but the average cost to local authorities when using independent care providers was only £12.30 (UKHCA 2009: 7).

The extension of 'user choice' through individual budgets and direct payments to older people from local authorities will continue to be a central theme in future provision, coupled with regulation and training to improve the quality of care; although the extent to which employers will in practice be required to employ qualified staff, and to which care staff will be required to be registered, remains unclear. Where an older person directly employs a care worker, the conjunction of the differing roles of care user and employer has possible consequences that emerge in our findings.

Chapter 3 provided background information on migration policy and practice relating to the sector, another area of policy in the process of rapid change. It notes that the UK health sector has historically relied heavily on migrant health professionals but through improvements in pay and conditions, training and 'Return to Practice' schemes has been working towards relative self-sufficiency in UK-trained doctors and nurses in the NHS in recent years; a strategy not yet adopted in social care. Freedom of movement for A8 workers following enlargement of the European Union in 2004 had not provided a significant new source of health professionals but had proved more important for the social care sector, with a particular influx of Polish workers. Foreign born carers from outside the EEA for the most part have entered the UK not through the labour migration system but as asylum seekers, students, family members, domestic workers or working holiday makers, or on ancestral visas. About 25,000 senior care workers have entered through the work permit system, and proposals to restrict their entry through the new points-based entry system concerned employers and trade unions. Reform of entry rules

for working holiday makers and for international students may simultaneously reduce the availability of young people from abroad to work in the sector. While policy on migration is developed in the Home Office, policy on social care is the responsibility of the Department of Health, and the evidence suggests some lack of synergy. The Migration Advisory Committee has recently provided a valuable forum for reviewing the evidence and advising government on skill shortages.

The UK has no reception or integration strategy for new migrants other than refugees, focusing instead on mitigating the impacts of migration on local services and communities. Elements of an integration strategy are in place, such as provision of English language teaching, but attendance at classes can be difficult for those doing shift work. The UK does have legislation providing some protection for the rights of employees, including legislation on discrimination and harassment which puts responsibilities on employers and requires local authorities to promote equality. The chapter outlines these responsibilities as a necessary precursor to considering some challenges in this regard which emerged from our survey and interviews with employers, migrants and older people.

Chapter 4 drew on national data sources and our own survey of employers to provide evidence on the employment of migrant workers in social care: the size and demographic profile of the migrant workforce, countries of origin, regions and sectors in which they are working, wages, training, turnover and immigration status. It showed that the number of migrant workers in care occupations has increased to unprecedented levels, accounting for 19 per cent of care workers and 35 per cent of nurses employed in the care of older people across the UK, with even higher percentages among those recruited in 2007 (28 per cent of care workers and 45 per cent of nurses). In London more than 60 per cent of care workers are migrants; and migrants are disproportionately found in the private sector rather than working for local authorities, where wages are higher.

The most frequent countries of origin are Zimbabwe, Poland, Nigeria, the Philippines and India. While Poland became the main country of origin of care workers immediately after the EU enlargement of 2004, inflows of A8 nationals have significantly decreased since 2006, and return migration has increased.

Recent migrants are more likely than the workforce already in the UK (i.e. including non-recent migrants) to work all shifts, to be enrolled in training and to have temporary contracts. LFS data, relying on self-reported wage levels, suggest that a significant proportion of care workers are paid below the National Minimum Wage (and that among them recent migrants are the most likely to be in that position); however, the variability in wage data between different data sources does not allow a definitive assessment of actual wage levels. These characteristics of

the migrant care workforce are relevant to our findings on their experiences at work, and contribute towards shaping employers' preferences in relation to migrant labour.

Chapter 5 explored the factors that lead to the recruitment of migrant care workers, drawing on our survey and on interviews with employers and with migrant workers. It considered the reasons behind the significant shortage of suitable applicants for care jobs, reporting the reasons employers gave for recruiting migrants and their recruitment strategies. It also reported the migrants' experiences of recruitment and employment in the care sector, highlighting interconnections between their immigration status, the restrictions attached to it, and their pathways into and within the social care labour market.

The overriding reason for recruitment of migrants given by employers is the difficulty of finding UK born workers. The vast majority of employers attribute their recruitment difficulties to low wages and poor working conditions in the sector. Nine in ten employers undertake at least some action to recruit on the local labour market, while one in ten rely solely on overseas recruitment. This is reflected in the fact that most migrant care workers are recruited *after* they are already in the UK.

Recruitment difficulties are reported not only in relation to care workers but even more by organizations employing nurses – as shown also by the significant over-representation of foreign born nurses in older adult care as opposed to the better-paid and more prestigious jobs in the NHS. The widespread perception of a shortage of UK born nurses in the provision of older adult care contrasts with the Government's confidence that the nursing workforce in the healthcare sector can rely on domestic training alone – a view which underlies the restrictions on nursing work permits.

Despite the primary role played by local recruitment difficulties in shaping the demand for migrant labour, our findings showed that migrant workers are often well regarded by employers. Reported advantages of employing migrants including their willingness to work all shifts, a 'good work ethic', a more respectful attitude to older people and motivation to learn new skills. In the in-depth interviews a number of employers also emphasized migrants' social skills and care ethos, sometime comparing migrant workers positively with UK born carers and job applicants. Of those who perceived the quality of care provided by their organization to have changed as a result of employing migrants, over 80 per cent believed that the quality of the their services had improved.

Employers also reported challenges related to employing migrants, the principal of which is lack of proficiency in English. A majority also considered that they required extra job training. Immigration regulations can present significant hurdles for employers, including delays in visa

processing, restricted opportunities for applying for work permits and fear of penalties for employing migrants not allowed to work.

Interviews with migrant carers showed that migrants' 'willingness' to accept unattractive working conditions can reflect the constraints related to their immigration status rather than genuine choice. Migrants subject to immigration controls may remain in their jobs for longer than EEA workers who are not prevented from seeking alternative employment. This raises questions about the implications of any higher reliance on EEA workers in the future for continuity of provision.

Chapter 6 considered the implications of employing migrant care workers for the quality of care, drawing on our evidence from employers, older people and migrant workers. It emphasized the importance which older people and care workers attach to the relational dimension of care and of communication, and the importance of warmth, respect, empathy, trust and patience in the care relationship. Older people made positive references to the care provided by migrants, sometimes perceiving caring skills to be associated with particular nationalities. Where there were language and other communication barriers between migrants and older people these were a constraint on the quality of care, though proficiency in languages other than English could in some contexts help to meet diverse care needs. Lack of knowledge of the customs of older people, for instance in relation to preparation of food and drink, was experienced negatively and suggested a lack of suitable induction training. Shortage of time allocated to care tasks and lack of continuity in care relationships (particularly for agency workers) was a challenge for all care staff but could have a negative impact on older people's attitudes to migrant carers. The mental health of some older people could present additional challenges in developing relationships if they became verbally or physically aggressive. Live-in workers in particular reported a lack of training and support in providing care for older people in these circumstances.

The findings underline the importance of creating working conditions for all workers – but particularly for migrant workers, given their potential language barriers and lack of local knowledge of customs – that facilitate communication and relationship building with older people. The working conditions of migrant workers and the quality of care for older people are thus unquestionably related issues. The findings point to the need to ensure access to appropriate language tuition; to the need for induction arrangements that inform new staff about everyday customs and the colloquialisms that older people may use to refer to their health and personal needs; to the need to favour the stability of the employment relationship, so as to facilitate the continuity of care and the positive development of its relational aspects; and to the need to provide additional training for those caring for people with mental health issues. The findings also raise the question whether the availability of migrant workers willing to

accept unfavourable working conditions enables some care homes and home care agencies to continue to provide care at lower operating costs, at the migrants' expense, than would otherwise be the case.

Chapter 7 looked more closely at migrant care workers' experiences of inequality and discrimination (less favourable treatment) in the care sector and their access to employment rights, drawing on interviews with migrants but also those with employers and our group discussions with older people. It showed how inequalities in working conditions and discrimination are shaped by race and immigration status as well as by conditions within the social care system. With regard to employment relations, it found incidence of migrant workers being treated less favourably than UK born workers in terms of longer hours of work and less favourable shifts, lack of guarantee of minimum hours (and hence pay), unpaid overtime, distribution of less popular tasks, wages, employers' payment of tax and national insurance (and hence social protection), access to training opportunities and promotion, and complaints and disciplinary and dismissal procedures. Live-in migrants faced particular challenges and enjoyed fewer rights (including ambiguity on the extent to which they are protected by the Working Time Directive and minimum wage regulations). In some cases migrants identified nationality or race, or immigration status, as the overt basis of discrimination. Those working directly for older people, and those with irregular immigration status, were particularly vulnerable in relation to time worked and pay.

A challenging dimension of the treatment of migrant care staff uncovered by the research relates to older people's preferences for particular kinds of carers and their treatment of care workers. There is rightly an emphasis in current policy debates on empowerment of care users, providing greater opportunity to direct their own care provision. There is nevertheless a need to ensure that the environment of dignity and respect advocated by bodies such as the Equality and Human Rights Commission⁹² includes respect for the dignity of those providing care services. There can be a tension here between the personalization agenda promoting user choice and control, in home care in particular, and the responsibility of an employer not to discriminate in the appointment or treatment of carers.

Our evidence reveals a continuum in the behaviour of some older care users from overt references to race, colour and nationality in negative comments about and towards migrant care workers, including verbal abuse, through a grey area in which the basis of the behaviour may derive from legitimate concerns about their language skills or knowledge of customs. Some employers and agencies indicated that they felt ill equipped to manage the tensions and

⁹² EHRC, 'From safety net to springboard: a new approach to care and support for all based on equality and human rights', Feb. 2009, <http://www.equalityhumanrights.com/en/publicationsandresources/Pages/Fromsafetynettospringboard.aspx>.

expectations to which this could give rise. They felt they had a responsibility, as managers of businesses and as carers of older people, to respect their wishes, but also had a responsibility not to discriminate against a job applicant or employee. While managers occasionally spoke to an older person about their treatment of a migrant carer, it was common practice to move a migrant carer from a situation in which an older person refused to be cared for by them or in which migrants (particularly those from Africa) were subject to verbal abuse. In some cases migrants were expected to continue to work with the older person concerned. Managers had often received no training and little guidance on how to handle the conflicting rights implicit in this situation. Older people employing a carer in their own home are least likely to have received guidance in this respect.

Migrants similarly reported little access to information or advice on their employment rights. The complexity of some migrants' employment status contributed to the difficulties they experienced in understanding their rights. Awareness of a general right to freedom from discrimination often did not include awareness of how to claim redress, except for the minority who were members of a trade union. While access to employment rights is also an issue for non-migrant care workers, lack of familiarity with the system, language barriers and anxiety over immigration status can present additional barriers.

In Chapter 8 we looked to the future to consider the potential demand for migrant care workers and hence assess the future relevance of the challenges we have identified. The actual demand will depend on a range of external factors we identify but the impact of which we cannot assess, including labour market conditions and future efforts made to raise the status of care work, affecting the extent to which UK workers, including men, will be attracted to care jobs. We therefore set out three projections (not predictions) of the workforce that could be needed to meet the demand for care to 2030, in order to illustrate the differing implications these could have for the need for migrant workers. The method used, based on official population projections, estimates the size of the direct care workforce needed assuming constant dependency care ratios and disability levels, and then builds scenarios on the possible contribution of UK born and foreign born care workers. It must be noted that these are not projections for future levels of *immigration*, only for the number of foreign born carers working in the care system (of whom, as now, the majority may come to the UK for other purposes and be recruited *within* the UK). We find that the total direct care workforce working with older people could increase from 642,000 in 2006 to 1,025,000 in 2030, if care dependency ratios remain as in 2006. In our medium scenario, which assumes that the *percentage* of migrant carers in the workforce will remain constant (19 per cent) over the projection period, the stock of migrant carers working with older people would need to increase from 122,000 in 2006 to 195,000 in 2030, an average annual growth of around 3,000 or 2.5 per cent. This would represent a slowdown in the short term – in comparison with the levels of growth of the

foreign born care workforce of the 2000s – but still a considerable recruitment challenge for the care sector.

In our low and high scenarios, providing two extreme cases useful for comparative purposes, the entire additional need for care workers and nurses would be met, respectively, by UK born or migrant staff. If the growth in the workforce were met entirely by UK born staff, the proportion of foreign born care workers would decline to 12 % by 2030. If the additional care workforce was provided entirely by migrants, our high scenario, the foreign born care workforce would have to grow by an average of 16,000 per year. Under this assumption, in 2030 one in two care workers working with older people would be foreign born, similar to the current proportion of all social care workers in London.

We also considered the potential contribution of alternative sources of labour, showing that the recent expansion of the social care workforce has in part occurred as a result of people who were formerly inactive, unemployed or employed in other occupations having taken up care jobs. However, evidence suggests that the domestic labour supply has responded only to some extent to the increasing work opportunities in the sector. Unsurprisingly, the propensity to take up care jobs has been relatively higher only among family carers and unemployed individuals, rather than students entering the labour market or people already employed in other occupations.

Finally, we discussed the implications of the current economic downturn, presenting evidence from recent unemployment data and reporting experiences of some employers interviewed at the beginning of 2009. Because of the relative stability of the demand for care – in comparison with other goods and services – the social care workforce is less exposed to the economic slowdown than workers in other less skilled occupations. However, unemployment figures have been rising and the number of vacancies for care worker jobs has fallen in the first months of 2009. There is some evidence that the domestic supply of workers available to take up care jobs may increase as a result of redundancies in other sectors and the reduction in household incomes pushing more inactive people into the labour market. However, the ability of care sector employers to recruit this additional workforce cannot be taken for granted because candidates with no experience of care work and no perceived career prospects in the sector may be considered unsuitable.

While acknowledging the undesirability of reliance on migrant workers as an alternative to raising wages and improving conditions in the sector, we conclude that – in the absence of a step change in public funding for care provision – the care sector is likely to continue to need to rely on a significant number of migrant care workers.

9.3 Potential implications for future migration and care policies

It is important to situate this discussion within the Government's broader review of the social care system. Migrant carers are currently fulfilling a vital role in care provision. The reliance on migrant labour is a symptom of the structural and funding challenges the care system is experiencing and, in the long term, migrants should not and cannot be the solution to those problems. To the extent that it is decided that they should be part of the solution, our findings suggest that their role should be planned, not an unintended consequence of pay and working conditions unattractive to other job seekers, and regulated to the mutual benefit of older people and the migrants who care for them. In that context, the trend towards care provision in an older person's own home, in some cases with the older person fulfilling the role of employer, provides a particular challenge.

We suggest that consideration needs to be given in particular to the following ten recommendations.

Recommendations

1. Increase the funding and status of care work

The Department of Health's social care review must address the need to ensure that the pay, conditions and status of care work, and the opportunities for training and career development, make the sector more attractive to locally resident men and women. Recent evidence from a BBC poll that only 2% of the public want social services budgets to be protected compared to 73% prioritizing health and education budgets, regrettably suggests that the Government may not face voter pressure to do so.⁹³ The 'low skill' categorisation of most care (as opposed to nursing) roles is problematic, reflecting the low level of training, lack of recognition of soft skills (the importance of which is so strongly highlighted in this study) and predominance of women in the workforce. Improvements in training, qualifications and pay would contribute to greater public acknowledgement of care workers' social contribution. Initiatives to make the sector more attractive could explicitly address the gender imbalance in the care workforce, tackling the stereotype that caring is women's work. The Government's recent Adult Social Care Workforce Strategy includes measures intended to raise the status of care work and recruitment to the sector, including funding for 50,000 social care traineeships and extension of registration to some home care workers, but will need to be backed up by improvements in pay and conditions to make a sustainable difference.

⁹³ BBC Populus poll of 1,007 adults for *Westminster Hour*, April 2009, http://news.bbc.co.uk/1/hi/programmes/the_westminster_hour/8007252.stm.

2. Retain a migration entry channel for senior care workers

We share the view of the Migration Advisory Committee (MAC) that it is not desirable in the long term for migrant workers to be recruited from abroad to fill posts which, because of poor pay and conditions, are unattractive to those already within the UK. In the short term, however, further restricting the entry channel for senior care workers would exacerbate the difficulty employers are experiencing in filling these posts and hence their ability to provide care services. The MAC advice that entry be permitted for senior care posts fulfilling certain criteria is thus a necessary interim measure and reduction in the required wage threshold to £7.80 appropriately reflects prevailing conditions in the care labour market.

3. Monitor the long-term need for a migration entry channel for lesser skilled care workers

There is no case for activating a new entry channel for less skilled care workers in the immediate future. Migrants recruited on the local labour market are still providing a significant workforce for these positions, the Government has recently taken some steps to boost local recruitment, and the current rise in unemployment may lead to more applicants from the UK born workforce, although not all may be considered suitable for care work. Our projections show, however, that the ageing population will require a significantly larger care workforce. Even if the percentage of migrants was to remain constant, a greater number of migrant carers would be needed. EU migration has declined, and there can be no confidence that wage levels in the sector will rise sufficiently to meet all of the growth in demand from within the UK. The impact of recent changes in entry rules for non labour migrants is a further relevant factor. The Home Office needs to recognise the contribution within the care workforce of those migrants who enter for other purposes – as spouses, refugees, students, domestic workers, working holiday makers or on ancestral visas. Changes in immigration rules could affect the availability of students, in particular, to fill these posts. A system to monitor labour shortages in care work, and the contribution which different categories of migrants are making in meeting those shortages, is needed; perhaps by expanding the Migration Advisory Committee’s remit to cover these less skilled posts. If in the long term there is an unmet demand for less skilled care workers government needs to consider allowing direct entry for migrants to take up these jobs. The alternative, if employers cannot recruit legal migrants to maintain care services, could be an increase in migrants working without permission. It would not be appropriate to use the (currently dormant) Tier 3 to create a channel for temporary workers. Temporary staffing is not a desirable option in this sector. It would run counter to the need for continuity in care, older people and employers being constantly faced with new staff adapting to their roles in a context where understanding cultural nuances and particularities of language can take time to acquire, and relationships with older people time to develop. A recent survey confirmed that the UK

public also prefers a system of permanent immigration to the rotation of people on a temporary basis.⁹⁴ If there is a need for a legal entry channel for care workers to meet labour shortages, it should be on a basis that allows long term employment, leading to eligibility for permanent residence. This would also help to ensure that migrant care workers have access to the same rights as their British counterparts.

4. Improve Government coordination and communication with employers

Until recently, reform of the migration system was being undertaken with little awareness of the potential implications for the staffing of the care sector; while social care debates equally lacked consideration of the potential impact on the demand for migrant workers. The recent Adult Social Care Workforce Strategy surprisingly still makes no mention of their role. The concern among care sector employers, recruitment agencies, trades unions and the Department of Health in 2008, when it became clear that access to the UK for senior care workers was to be further restricted, and that changes in the rules for working holiday makers and students could also restrict the supply of care staff, drew attention to the need for greater awareness among policy makers of the implications of reforms in their respective fields. Government needs to ensure that there are structures in place that enable migration policy to take account of staffing needs in the care sector and of government objectives in relation to up-skilling the workforce, continuity of care and protection of vulnerable workers. Most employers had faced procedural difficulties in securing permits and visas for senior care workers and in employing other migrants subject to immigration controls. These included delays, inconsistency in outcomes, and difficulty securing information from the UK Border Agency (UKBA) on whether staff who applied from within the UK had permission to work. These challenges were exacerbated by the difficulty of keeping up with frequent changes in the immigration rules. Given the penalties for employing a carer not allowed to work, arrangements should be in place to allow employers to check eligibility without undue delay. Delays in securing Criminal Record Bureau clearance is a further obstacle in the recruitment process which needs to be addressed.

5. Promote integration and access to long term residence and citizenship

Consideration needs to be given to fostering the integration of migrant carers not only within the labour market but within the wider community. It is not in the interests of older people, nor of employers, if carers face unnecessary barriers to integration and are discouraged or prevented from remaining in the UK. In that context, their situation should be included within

⁹⁴ German Marshall Fund, *Transatlantic Trends* 2008, <http://www.transatlantictrends.org/trends/>.

any future development by the Home Office or Department for Communities and Local Government of an integration strategy for newcomers. Furthermore, if the Government proceeds with its intention to 'speed up the journey to British citizenship and permanent residence' only for those who demonstrate 'active citizenship' through voluntary work in the community, it should recognise the significant contribution that migrant care workers are already making and that it would neither be appropriate nor feasible in practice for many to make a further voluntary contribution given the long hours and shifts that they are already working.⁹⁵

6. Ensure access to language and skills training and guidance on cultural norms

Language and the colloquialisms and nuances of personal communication, coupled with understanding of cultural norms relating to personal care, can be a significant challenge for migrant workers. Notwithstanding examples of good practice, the language and induction training currently available would seem from the evidence to be insufficient. Migrants are often employed by small care providers with few staff: employers who are not in a position to run language classes or produce the kind of induction literature that migrant carers need. Government and skills agencies need to ensure that such provision is made and guidance material available; and that it reaches those workers working shifts in a '24 hour care' environment, with low capacity to access regular classes or to pay tuition fees. The exclusion of non EU migrant care workers from publicly funded NVQ training until resident for three years in the UK is counterproductive, as care users benefit from that training. NVQ qualifications also represent an opportunity for career development which is likely to help with retention. Government may want to reconsider this restriction in light of its overarching objective of improving skill and qualification levels in the sector.

7. Care sector organisations should address issues relating to migrant care staff

The Care Quality Commission has responsibility in England for supervising compliance with standards in the care sector, including induction, training and the ethos of care homes. We recommend that it consider the implications of our findings for future standard setting for residential and domiciliary services, and within the focus of its inspections and thematic reviews. Statutory and independent sector organisations engaged in older adult care equally

⁹⁵ Impact Assessment for Borders, Citizenship and Immigration Bill,
<http://www.ukba.homeoffice.gov.uk/sitecontent/documents/managingourborders/border-cit-imm-bill/supporting-documents/iaofearnedcitizenship?view=Binary>.

need to take account of the significant number of migrant carers in the sector and of the issues which this raises. There is a broader need to ensure that care staff have access to accurate information on the conditions attached to their immigration status, their rights at work and where they can access further information and support. In this trades unions and professional associations in the care sector have a key role to play. There is also a need for government to review certain restrictions on those rights, for instance the ambiguity of live-in workers' rights under the Working Time Directive and minimum wage regulations and the de facto exclusion of irregular workers from the protection of discrimination law. Those migrant care workers who enter through the points based system are working for employers who must, since 2008, also be licensed by the UKBA to sponsor their entry. The process of applying for a license includes satisfying the UKBA that the organisation meets certain criteria including, in the care sector in England, that it is registered with the Care Quality Commission. Although resource constraints appear to have meant limited inspection of employers before the license is granted, the UKBA could use this process to secure agreement to broader conditions such as ensuring that migrant workers have access to the advice and language training that they need.

8. Address the prevalence of discrimination and harassment

The frequency in migrant carers' reports of less favourable treatment in pay and working conditions suggests a systemic inequality which should be investigated. There is also a need for the appropriate authorities to respond to the hostility some older people are expressing towards migrant carers and the concerns of managers in this regard. We suggest that the Care Quality Commission and the Equality and Human Rights Commission, in consultation with employers, unions and migrant representatives, should consider how this might be addressed, including ensuring that managers and care staff have appropriate training on equal opportunities in employment and service provision, and written guidance on best practice to refer to; that there is a mechanism in each work place for workers to have their concerns addressed appropriately; and that older people and their families have guidance on their responsibilities as employers in home care. Those care users and families who are not initially comfortable with care provision by migrant workers also need to be helped to understand the essential contribution which migrants now make to care services and that staff, like older people, have a right to be in an environment that respects their dignity and self worth.

A further opportunity to ensure that the rights of carers and of older people are protected arises from local authorities' statutory duty to promote equality of opportunity and good relations, and to use their leverage through commissioning of care services to ensure that care providers also have procedures in place to do so. Local authorities should also ensure that in their relationship with older people and their families through direct payments and

personalised budgets they provide clear guidance on their responsibilities towards carers, and could play a mediation role should any difficulties arise in the employment relationship.

9. Monitor the implications of the direct employment by older people of migrant home care workers

The emphasis on extending user choice and control in home care, and the consequent growth in the direct employment of care workers by older people and their families, has implications for the protection of older people and of care workers. Many of the safeguards in place for care homes and home care agencies, including inspection by the Care Quality Commission and requirements in relation to criminal record checks, do not apply where carers are directly employed. Intrusion by the state into private homes is a sensitive issue and not to be undertaken lightly. Nevertheless, our findings suggest that consideration should be given to the consequences of this development and the potential need for additional safeguards should be kept under review. The findings also point to the need to improve access to information and advice for older people and their families, particularly those who take on the responsibilities of an employer, and support in fulfilling the additional responsibilities this imposes. This underlines the need for external intermediaries, such as local authorities contributing to the cost of care, to have a guidance and support role in direct employment relationships, ensuring that older people, their families and migrant workers are aware of their respective rights and responsibilities.

10. Foster public recognition of the invaluable contribution of care workers

The contribution which care workers are making to the care of older people is invisible to the majority of the public who are not in regular contact with the care system. Within a negative political climate, it is easy for the public to overlook the particular contribution which migrant care workers are making, doing a demanding job for low financial reward. As debates on reform of the care system are taken forward, the essential contribution of the care workforce as a whole, and of migrant carers among them, in providing quality care for older people, should be given greater public recognition and – along with the focus on the rights of older people – lie at the heart of proposals for reform.

Appendix 1. Analysis of Labour Force Survey data

This appendix explains the strengths and limitations of the LFS as a primary basis for our analysis of the foreign born care workforce. It also describes how we constructed a pooled sample of respondents by merging eight LFS quarters (January 2007 – December 2008) in order to avoid duplications (individuals included more than once) and increase the sample size.

A1.1 Quality of the LFS estimates

The Labour Force Survey (LFS) is the major household survey carried out by the Office for National Statistics and provides quarterly estimates of the UK resident population and workforce. It provides data on a consistent set of variables over long timeframes and is highly regarded because it uses internationally agreed concepts and definitions. It also has the remarkable advantage of recording a large number of individual characteristics. The LFS is commonly used to answer questions about migrant workers in employment because it contains questions about nationality, country of birth and date of arrival in the UK, offering the analyst various options in estimating the employment of foreign or foreign born workers and how it changes over time. However, it does not collect any information on immigration status at the time of the interview or on arrival in the UK – e.g. whether migrant respondents entered on a work permit or dependent visa, or have refugee status, and so on.

Country of birth is typically preferred to nationality as proxy information to identify the migrant population and workforce. There are two main reasons for this: first, information about country of birth would seem to be more relevant to questions about migration – people who have come to the UK from abroad – than information about nationality, which can change over time; second, answers to questions about country of birth are likely to be more reliable than self-reported information about nationality.

There are, however, some important caveats to make about the use of country of birth data in this context. In particular:

- ‘Migrant’ workers and ‘foreign’ workers are not the same thing: over one-third of those born abroad and in UK employment in 2008 were UK nationals rather than foreign nationals.
- Many migrant workers entered the UK a long time ago, some of them as children. Therefore, the ‘foreign born’ definition includes a wide and heterogeneous group of

people. This issue can be addressed by combining information about country of birth with the year of entry to the UK.

The LFS is not an ideal source to estimate the social care workforce, because neither the classification of occupations (Standard Occupational Classification: SOC 2000) nor the classification of industries (Standard Industrial Classification: SIC 2003) lends itself to defining social care roles particularly well (Eborall and Griffiths 2008). For this purpose the four-digit occupational classification proves to be more appropriate (Simon and Owen 2005, 2007). The analysis of LFS data presented in this report is mainly based on the occupational categories 'care assistants and home carers' (code 6115 in the SOC 2000), and 'nurses' (code 3211 in the SOC 2000). A significant limitation of these categories is that they do not enable one to separate out those working exclusively for older people. Another problem is that the category 'care assistants and home carers' covers both care workers and senior care workers, and does not distinguish between the two. More specifically, this SOC code covers a multitude of job roles (including some in children's social care) and does not exclusively determine the industry in which the person works (SfC&D 2009). Cross-tabulations of occupation and industry data do not solve this problem because the SIC 2003 classification includes many care workers under the unspecific category 'human health activity'. Finally, some interpretative caution is also needed because LFS estimates based on the respondent's main job can be misleading in the social care sector where many care workers work for more than one employer (Eborall and Griffiths 2008).

A further problem is that the LFS underestimates the volume of the social care labour market, as shown by the comparison with the more reliable figures based on the NMDS-SC. For example, LFS estimates (average over four quarters) for 2007 provide a figure of 640,000 social care workers in the UK, while estimates based on the National Minimum Datasets for Social Care (NMDS-SC)⁹⁶ suggest that in 2006/7 764,000 direct care workers were employed in adult care in England only (Eborall and Griffiths 2008). There may be various reasons for this gap, such as the exclusion from the LFS sample of people living in communal establishments (including residential and nursing homes), a lower coverage of live-in carers and people occupying casual jobs (e.g. Skills for Care estimated 152,000 care workers to be employed in England by people receiving direct payments in 2007/8) or the inaccuracy of the scaling factor – LFS estimates are derived from a relatively small sample of households and have to be scaled up by a factor of several hundred to tally with estimates of the relevant total population figures.

⁹⁶ The NMDS-SC is the most comprehensive and reliable source of information on the care sector workforce in England. Between 2007 and 2008 data was collected from nearly 20,000 organisations providing adult care services.

Arguably the excluded groups are likely to include disproportionately large numbers of migrants (Walling 2006). There are in fact specific reasons why migrant households are more likely to escape the survey, leading to the under-representation of the migrant workforce in the LFS estimates. People who have moved to the UK in the six months preceding the survey are excluded because the definition of ‘usually resident’ population adopted by the survey requires at least six months of stay in the country. Recent migrants are also more likely to refuse to answer the survey or provide incomplete information because of language barriers and mistrust of the interviewers – especially if their residence or work status is not entirely compliant with immigration regulations. They are also more mobile than the long-term resident population, and therefore are less likely to fulfil the requirement of six months’ continuous residence at the current address needed to be included in the LFS sample. For all these reasons the estimates provided by the LFS are likely to be conservative, although their level of inaccuracy is hard to predict.

A1.2 Construction of a multi-wave sample

As the number of care workers included in each LFS quarter is quite small when the sample is broken down by selected characteristics, estimates presented in this report were based on a *multi-wave sample*. More specifically, we pooled a sample drawing on the eight LFS quarters between January 2007 and December 2008. By doing so we obtained a total sample size about 2.2 times as large as that typically included in a single quarter (see below), making our estimates more robust. Data for each of these quarters are available in the new calendar format, to which the LFS recently switched, in line with EU regulations.

Because each household in the LFS is surveyed in five successive quarters, we have adopted the same approach used by IPPR (2007), including each household only once in the appended data set. The *thiswv* variable, which gives the information on how many times each participant has been interviewed, was used to avoid duplications. When selecting waves, preference was given to waves 1 and 5 (i.e. individuals interviewed for the first and last time), since these are the waves collecting information on income. The selection procedure we adopted is represented in figure A1.1.

Representations of individual respondents are colour coded in the diagram. For example, respondents in wave 1 in the third quarter (July–September) of 2007 are shaded grey. Their progress through the survey waves can be traced by following the grey shading diagonally through to wave 5 in Q3 of 2008, when their participation comes to an end. The observations used in the analysis are bordered by a dashed line, and represent the maximum number of waves that can be included without any one respondent being represented more than once in the sample.

FIGURE A1.1: SELECTION OF RESPONDENTS WITHIN LFS QUARTERLY SAMPLES

		2007				2008			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Survey wave	1	1	1	1	1	1	1	1	1
	2	2	2	2	2	2	2	2	2
	3	3	3	3	3	3	3	3	3
	4	4	4	4	4	4	4	4	4
	5	5	5	5	5	5	5	5	5

--- included in the sample

It is important to bear in mind that the appended sample cannot be used to estimate absolute numbers of care workers in the UK. The sample of each LFS quarter is designed to provide estimates of the UK population and workforce by weighting each unit according to its expected frequency in the overall population. However, since in the appended data some of the waves are dropped to avoid double counting, we can no longer rely on the weight variables (*pwt07* and *piwt07*) to relate the sample to the universe it represents. Therefore, the resulting pooled sample represents a group of observations that cannot be compared with the quarterly estimates of the LFS (IPPR 2007). For this reason, the figures based on our pooled sample are analysed in terms of proportions rather than numbers.

We use the country of birth as a proxy to identify the migrant workforce. We introduce a further distinction between ‘recent migrants’ (i.e. people who came to the UK in the last ten years) and ‘non-recent migrants’ (i.e. people who have been in the country for more than ten years). The ten-year threshold was arbitrarily introduced to capture the recent changes in the social care workforce, with particular reference to the large expansion in the number and proportion of migrants employed.

Appendix 2. Employer survey: sample characteristics

This appendix illustrates the design and sample characteristics of our survey of organisations providing residential and home care for older people. The aim of the survey – carried out in the first half of 2008 – was to explore the current employment of, and potential future demand for, migrant workers in the care of older people. The questionnaire mainly included closed-end questions and focused on the structure of the workforce employed at the time of the survey, the reasons for the reliance on migrant workers, the recruitment process, and the management implications of employment of migrant staff. For the sake of consistency, employers were asked to regard as ‘migrants’ people who were born abroad.

As mentioned in section A1.1, LFS data are not specific to the older adult care sector. This was a further reason – in addition to the focus of this research – to target organizations providing care for older people in our collection of primary data from employers. The main component of our fieldwork was a postal survey of residential and nursing homes. Because of the high level of uncertainty about the response rate in postal surveys, we initially included in our survey only providers of residential care. A random sample of 3,800 organizations was drawn out of 12,520 care homes and nursing homes for older people listed in the Laing & Buisson data set of residential care providers in the UK. In order to increase the coverage of the survey in terms of workforce, a higher probability of extraction was attributed to medium and large organizations.

Following the satisfactory completion of the survey by a sufficient number of residential care providers, we decided to include in our sample home care organizations as well. A second postal survey (with an adapted questionnaire) was distributed to a random sample of 500 providers of home care for older people drawn from the list of members of the UK Homecare Association (UKHCA).

For both surveys the response rate was 12 per cent. This was a relatively good outcome, comparing favourably with the lower response rate (9 per cent) from social care organizations obtained by the survey of employers carried out for the Low Pay Commission in the same year.

Both surveys were also made available online and advertised in the newsletters of the Social Care Association and UKHCA, so as to reach out also to potential respondents who preferred to respond via the internet.

Overall, 557 completed questionnaires were returned. Respondents were employing at the time of the survey over 13,800 care workers and nearly 1,900 nurses.

Table A2.1 illustrates the distribution of responding firms in each sector by type of service. Our sample is not statistically representative of the overall older adult care sector, the most significant biases being:

- In terms of distribution by type of service, the under-representation of the home care sector. In our sample there is one home care agency for every six providers of residential care for older people (with or without nursing facilities), while the same ratio among all businesses registered with the Care Quality Commission (formerly the CSCI) is one in three. This was the result of our methodology, which prioritized residential care providers.
- In terms of distribution by sector, the under-representation of local authorities, particularly among home care providers. This was due to a low response of local authorities to the survey. The voluntary sector is also slightly under-represented.

TABLE A2.1: BREAKDOWN OF THE SAMPLE^a BY SECTOR AND TYPE OF SERVICE

Sector	Type of service			Total
	Residential home	Nursing home	Home care	
Private	43%	27%	12%	82%
Voluntary	10%	3%	2%	15%
Local Authority	3%	0%	0%	3%
<i>Total</i>	<i>56%</i>	<i>30%</i>	<i>14%</i>	<i>100%</i>

^a n = 557.

Source: COMPAS survey of employers (2008).

As mentioned above, in order to increase the coverage of our survey in terms of workforce we included in our sample only a few micro-businesses and oversampled larger residential care providers. However, the response rate from large organizations (i.e. those employing more than 50 care workers) was lower than for smaller providers. This means that the distribution by number of employees of the surveyed organizations in our data set is skewed towards medium-sized organizations (10–49 employees), under-representing both micro and large businesses (see table A2.2). The under-coverage of micro-businesses may be particularly significant because even the National Minimum Dataset for Social Care (NMDS-SC) – the benchmark of the comparison in the table – provided limited coverage of the smallest care providers.

TABLE A2.2: DISTRIBUTION OF SURVEYED ORGANIZATIONS BY NUMBER OF EMPLOYEES: COMPARISON WITH NMDS-SC

Number of employees	Compas survey	NMDS-SC ^a
< 10	6%	11%
10-49	75%	67%
50 +	19%	22%
Total	100%	100%
N	504	10,281

^a Older people users, 31 Dec. 2008.

The main issue with the distribution of the surveyed organizations across UK regions is the poor coverage of the London area. According to the CSCI register and the NMDS-SC, 12–13 per cent of the organizations providing care for older people are based in London, while this is the case for only 3 per cent of the respondents to our survey (table A2.3). The main reason for this is likely to be the under-representation of the home care sector, domiciliary care being the prevailing type of care service in London. In contrast, the regional distribution in our data set over-represents providers based in the rest of the south of England. Part of this bias may be explained by some employers based in the outer London area reporting themselves as based in the South East.

TABLE A2.3: DISTRIBUTION OF SURVEYED ORGANIZATIONS BY REGION, COMPARISON WITH NMDS-SC AND CSCI REGISTER

Region	Compas survey		CSCI register ^a	NMDS-SC ^b
	UK	England	England	England
North East	4%	5%	5%	5%
North West	12%	15%	15%	16%
Yorkshire & Humberside	5%	6%	7%	7%
East Midlands	7%	9%	10%	11%
West Midlands	6%	8%	11%	11%
East Anglia	8%	10%	11%	11%
London	3%	3%	13%	12%
South East	19%	24%	17%	17%
South West	17%	20%	12%	11%
Wales	8%			
Scotland	6%			
Northern Ireland & Isle of Man	4%			
Total	100%	100%	100%	100%
N	538	442	14,516	18,282

^a Care homes and nursing homes for older people and domiciliary care organisations, accessed Sept. 2008.

^b Organizations providing care for older people users, cross tabulations at 31 Dec. 2008.

Appendix 3. Migrant care worker interviews: sample characteristics

Interviews were carried out with 56 migrant care workers who were working in residential and nursing care homes or in home care settings. This appendix describes the criteria adopted in the selection of migrant interviewees and provides a breakdown of the sample by demographic and employment characteristics.

The selection of interviewees was based on the following sampling criteria, relating to the questions of the research:

- *Care setting/employer*

The sample included migrant care workers in both institutional and home-based care settings, employed by care homes, by home care agencies or directly by older people/family members, with a view to exploring differences in migrant workers' experiences across care settings and employers.

- *Care occupation*

Interviewees had experience of directly caring for older people in their current or previous jobs in the UK in the above care settings. Given that the experiences of migrant nurses in the UK has been more widely researched, the sample included mainly home carers, care assistants and senior care workers.

- *Country of origin and immigration status*

The sample included workers from the principal countries of origin of the foreign born social care workforce (referred to in chapter 4) within Eastern Europe, Africa and Asia, with varying different immigration status (including EU nationals, work permit holders, students and refugees), in order to explore the influence of immigration status on workers' experiences.

- *Date of arrival in UK*

Most interviewees had arrived in the UK during the past ten years (between 1998 and 2007), enabling us to explore more recent experiences of migration to the UK and entry into the UK care sector, and the influence of more recent immigration policies/statuses on workers' experiences.

A purposive sampling approach was adopted, based on the above criteria and using different methods of accessing interviewees, which involved approaching migrant care workers through:

- care homes or home care agencies where they were employed;

- migrant community organizations;
- churches and faith-based groups;
- trades unions.

The sample achieved comprised migrant care workers in England who were mainly employed in London and the South East of England (where foreign born workers form a higher proportion of the local social care workforce compared with other regions, as indicated in chapter 4), but also in the West and East Midlands, the South West of England, the North West of England, and Yorkshire.

A3.1 Interview process

Interviews were carried out between June and December 2007. Prior to the interview, all interviewees were given written information on the research, which the interviewer discussed with them (in their first language where necessary) before obtaining their written consent to participate in the research.

Interviews were carried out face-to-face using a semi-structured interview schedule. Some interviews with respondents from India and Sri Lanka were carried out in the respondent's first language (with an interviewer who was proficient in that language). All other interviews were carried out in English (although respondents' level of proficiency in English language varied, which may have affected the interview process).

The interview duration varied between 50 and 90 minutes. All interviews were recorded.

A3.2 Data analysis

All interviews were transcribed and were coded using NVivo 7, according to a framework developed on the basis of the research questions, the interview schedule and emerging themes of the interviews.

A3.3 Sample characteristics

Most respondents were female (49 compared with 7 male respondents), while the age of respondents was relatively evenly distributed between the lower limit of 21 and the upper limit of 61.

TABLE A3.1: AGE OF RESPONDENTS

Age group	No. of respondents
21-30	16
31-40	15
41-50	12
51+	7
Total	50 ^a

^a Age refused: 6.

The principal countries of origin of respondents (based on their nationality as well as country of birth) were Zimbabwe, the Philippines, India and Eastern European countries (including the EU member states of Czech Republic, Hungary, Lithuania, Poland and Slovakia; one respondent was from Albania). These countries correspond with the principal countries of origin of the foreign born social care workforce, based on LFS data (see chapter 4).

TABLE A3.2: NATIONALITY OF RESPONDENTS

	Country of nationality	Number of respondents
Africa	Gambia	1
	Kenya	2
	South Africa	1
	Zimbabwe	15
Asia	China	1
	India	7
	Philippines	13
	Sri Lanka	2
Eastern Europe	Albania	1
	Czech Republic	2
	Hungary	1
	Lithuania	3
	Poland	4
	Slovakia	3
Total		56

Most respondents – 52 out of 55 providing the information – had arrived in the UK in the past ten years, during the period 1998 to 2007. More than half had arrived in the past five years, from 2003 to 2007. Migrant interviewees entered the UK on various types of visas and with varying immigration status. At the time of the interview, most of them either had indefinite leave to remain or were applying for a work permit (table A3.3).

TABLE A3.3: IMMIGRATION STATUS OF RESPONDENTS ON ARRIVAL IN THE UK AND AT TIME OF INTERVIEW, BY COUNTRY/REGION OF ORIGIN

Entry status	No. of respondents	Current status	No. of respondents
Zimbabwe	15		15
Tourist visa	7	ILR ^a	2
		Student visa	1
		Tourist visa expired	1
		Work permit	2
		Asylum seeker	1
Student visa	3	ILR	1
		Student visa expired	1
		Asylum application refused	1
Asylum seeker	3	Asylum seeker	1
		ILR	2
Spouse (of refugee)	2	ILR	2
Other Africa	4		4
Student visa	2	Same	2
Domestic worker visa	2	Same	1
		ILR	1
Philippines	13		13
Work permit	8	Same	6
		ILR	2
Domestic worker visa	3	Same	2
		ILR	1
Student visa	1	Same	1
Tourist visa	1	ILR	1
India	7		7
Domestic worker visa	6	Same	3
		ILR	3
Spouse of British national	1	Same	1
Other Asia	3		3
Student visa	1	Work permit	1
Domestic worker visa	2	Same	1
		ILR	1
Eastern Europe	14		14
EU national (WRS) ^b	10	EU national (WRS)	4
		EU national	6
Aupair visa	1	EU national	1
Student visa	2	Same	1
		EU national	1
Tourist visa	1	EU national	1
Total	56		56

^a Indefinite leave to remain. ^b Worker Registration Scheme.

Just over half of the respondents had a health and social care related qualification or were undergoing training (at the time of interview) in health and social care (table A3.4).

TABLE A3.4: RESPONDENTS' QUALIFICATIONS/TRAINING IN HEALTH AND SOCIAL CARE

	Number of respondents
<i>Qualifications obtained prior to coming to UK</i>	
Degree/diploma in nursing	11
Other health and social care degree/diploma	4
<i>Qualifications or ongoing training in the UK</i>	
Higher degree in health and social care	1
Degree in health and social care	1
NVQ 4 health and social care	3
NVQ 3 health and social care	5
NVQ 2 health and social care	7
<i>No qualifications in health and social care</i>	24
<i>Total</i>	55 ^a

^a One respondent had a qualification prior to coming to the UK as well as being currently enrolled on an NVQ programme in the UK. One value is missing.

Respondents had experience of providing care for older people in different care settings in the UK. As shown in table A3.5, around half of the respondents were currently (or had recently been) working in a residential or nursing home, while the other half were currently (or had recently been) working in home care settings, including live-in care (those living with the care user in the user's home) and live-out home care (those carrying out home care services in the user's home but not living with the user). A few were currently working in residential or nursing homes as well as working in home care provision. Several respondents had experience of working in both residential/nursing homes and home care provision, based on both current and previous care-related jobs in the UK.

TABLE A3.5: CARE SETTING IN WHICH RESPONDENTS WERE PROVIDING CARE FOR OLDER PEOPLE^a

Care setting	Number of respondents
<i>Care homes</i>	
Nursing homes	15
Residential homes	8
Residential and nursing home	3
<i>Home care</i>	
Live-in	18
Live-out	9
<i>Care homes and home care (live-out)</i>	3
<i>Total</i>	56

^a based on respondents' current or most recent job directly providing care

As shown in table A3.6, most respondents were currently (or had recently been) employed as *care assistants* (working in residential/nursing homes or live-out home care provision) or *live-in care workers*. The current (or most recent) position of other respondents included *senior care assistants* and *nurses*.

TABLE A3.6: RESPONDENTS' CURRENT OR MOST RECENT JOB (DIRECTLY PROVIDING CARE FOR OLDER PEOPLE)

Current or most recent job(s)	Number of respondents
Care assistant	28
Live-in care worker	17
Live-in care worker and care assistant	1
Senior care assistant	7
Registered nurse	2
Sheltered housing warden	1
<i>Total</i>	<i>56</i>

Respondents' employers varied across and within care settings, as shown in table A3.7 below. Of those respondents working in residential/nursing homes, most were employed by a private residential/nursing home or by a private care group that owned the residential/nursing home in which they worked. A few were agency workers who were placed in care homes and were contracted and paid by the agency.

Respondents working in home care (live-out) were employed either by home care agencies or by the older people for whom they cared (one respondent was employed by a local authority). Among those providing live-in care, some had multiple employers. This concerned respondents who were sometimes paid by the home care agency through which they worked (when providing care for clients receiving publicly funded care paid by the local authority) and at other times directly by older people/family members (when providing care for clients who were self-funding or in receipt of direct payments). Other respondents providing live-in care were employed directly by older people/family members, having found their jobs through an agency that supplied domestic staff, through a home care agency, or through informal networks.

TABLE A3.7: RESPONDENTS' EMPLOYERS

Care setting	Employer ^a	No. of respondents
Care homes	Private nursing or residential home	10
	Private nursing or residential home owned by care group	13
	Private care agency	3
Home care (live-out)	Private home care agency	4
	Private care agency	1
	Local authority	1
	Older person (recruited through voluntary sector home care agency)	1
	Older person (recruited through word of mouth)	2
Home care (live-in)	Private home care agency or older person/family (recruited through home care agency)	5
	Older person (recruited through private home care agency)	1
	Older person (recruited through private domestic staff agency)	2
	Older person (recruited through word of mouth)	7
	Family of older person (recruited through private domestic staff agency)	2
	Family (recruited through word of mouth)	1
Care homes	Private care agency	2
and home care	Private nursing home and private home care agency	1
<i>Total</i>		<i>56</i>

^a Organization/individual responsible for paying respondents' wages. Some respondents had more than one employer, as indicated (e.g. those working for a nursing home and for a home care agency). Four respondents working as live-in care workers who were paid directly by older people/family members referred to being self-employed.

Appendix 4. Focus groups with older people

Five focus group discussions were carried out with older people to explore their experiences and preferences for care, including care relationships with migrant workers. The focus groups comprised:

Current care users:

- two focus groups carried out in residential care homes located in the South East of England;
- two focus groups carried out at day care centres with home care service users in London.

Prospective care users:

- one focus group carried out with members of community groups for older people based in London.

The focus groups were organized directly by the residential care homes and day care centres approached, or through voluntary organizations for older people.

The five focus groups comprised 30 participants in total. Participants were predominantly female (some male participants were present in one of the focus groups in a residential home, in one of the groups with home care service users, and in the group with prospective care users). Participants in four focus groups were White British; the fifth comprised British Asian participants. Participants in the focus groups with home care service users were mostly receiving publicly subsidized care. Participants in the focus groups in residential homes included both those receiving publicly subsidized care and those self-funding their care.

The focus groups were carried out between December 2007 and March 2008. All participants were given written information on the research which the interviewer discussed with them (through an interpreter where necessary) before obtaining their written consent to participate in the research.

The discussions were carried out using a semi-structured topic guide. In the focus group with British Asian participants an interpreter was present to carry out interpretation in the case of some participants who were not proficient in the English language. The duration of the discussions was approximately one hour. All group discussions were recorded and transcribed.

Appendix 5. Projections of future demand for migrant care workers

This appendix presents the methodology we adopted to carry out projections for future trends in the demand for UK and foreign born social carers and nurses working in care of older people in the UK.

Our model is cell-based and consists of three components. The first estimates the base year numbers of carers (care workers and nurses) working with older people and the respective dependency care ratios; the second uses the official demographic projections of the older population (by age group and gender) to estimate the number of carers required for maintaining constant dependency care ratios; the third estimates the numbers of UK and foreign born carers required on the basis of low, medium and high assumptions in relation to the significance of the foreign born workforce. The number of carers relates to the actual number of individuals in the workforce, i.e. takes into account multiple job holders. A discussion of the advantages and limitations of different types of workforce measurements in social care can be found in the Skills for Care annual report (Eborall and Griffiths 2008).

As mentioned elsewhere in this report, assessing the size and breakdown of the direct care workforce in the UK presents some statistical difficulties, particularly with regard to the categorization and recording of data in the different UK countries and because of the information gaps in the exact numbers working with older people (Moriarty 2008), as well as on the number of migrant workers. In order to estimate the number of care workers and nurses working with older people – and the numbers of migrant carers within these groups – at the beginning of the projection period (2006) we have pooled data from various sources. To cope with some information gaps, we also introduced some simple assumptions reflecting the best of our knowledge.

As a basis for estimating the number of care workers in older adult care at the beginning of the projections, we used the Skills for Care estimate of 905,000 direct care workers' jobs in England in 2006/7. According to the latest NMDS-SC tabulations (31 December 2008), 93 per cent of those are care worker or senior care worker positions, corresponding to a headcount of 841,650.

However, this includes some degree of double counting because of people holding multiple jobs. Skills for Care estimates this at about 17 per cent for the whole social care workforce. Assuming that the same proportion applies to care workers, this reduces the headcount to 697,436 individuals. Again on the basis of the NMDS-SC, 71 per cent of care workers and senior

care workers work with older people. This leads to an estimate of 495,180 carers in older adult care (in England only).

As there are no comprehensive estimates for the other UK countries, we based our estimates for Scotland, Wales and Northern Ireland on a comparison between NMDS-SC and LFS data. For England, the LFS estimates the number of care assistants and home carers in 2007 at 503,240 (average over four quarters). This is considerably lower than the more reliable estimate based on the NMDS-SC, suggesting that the LFS estimate should be multiplied by a factor of $697,436/503,240 = 1.386$. Assuming this is the same for other UK nations, we apply this multiplier to the LFS estimate of 149,287 care assistants in Scotland, Wales and Northern Ireland and obtain a figure of 206,895. As there is no reason to assume that the proportion of care workers working with older people is different in the rest of the UK (the proportion of older people in the population is almost identical to the population in England), we assume again that this is 71 per cent, reaching an estimate of 146,896 care workers in older adult care in Scotland, Wales and NI.

Summing up the two estimates for England and the other UK countries leads to a total of 642,076 care workers in older adult care in 2006/7.

As there is no better available estimate of the number of registered nurses working with older people – the NMC register does not provide information on the medical specialty or type of service – our starting point is again the Skills for Care estimate based on the NMDS-SC, according to which there were 90,000 staff in professional roles in England in 2006/7 (Eborall and Griffiths 2008). According to the latest NMDS-SC tabulations (31 December 2008), 65 per cent of those are nurses working with older clients, which leads to an estimated headcount of 58,597. Assuming the same degree of double counting due to people holding more than one job as for care workers (17 per cent), we estimate at 48,557 the number of nurses (individuals) working in older adult care in England in 2006/7.

This figure corresponds to 9.1 per cent of all nurses registered with the NMC in England at 31 March 2007 (531,966). We assume that the same proportion of those registered in Scotland, Wales and Northern Ireland (128,536 overall) work in care for older people, thus obtaining an estimate of 11,733.

We therefore estimate at 60,290 the total number of nurses working with older people in the UK at the beginning of our projection period.

The stock of care workers and nurses born outside the UK at the base year of the projections is estimated using the proportion of the foreign born workforce recorded by our survey of employers (19 per cent and 35 per cent respectively). Therefore, we estimate that about 122,000 carers and 21,000 nurses were born outside the UK in 2006.

The second part of the model estimates the number of carers of older people required to maintain the current dependency care ratios of care workers and nurses to the older population – i.e. the ratio of the numbers of care workers and nurses (according to the above estimates) to the number of older people aged 65 years and over. The dependency care ratios in 2006 were 0.0663 for care workers (i.e. 1 care worker per 15.1 older people) and 0.0062 for nurses (i.e. 1 nurse per 160.7 older people).

The demographics which form the basis for the workforce projections are the most recent official population projections, which have 2006 as their base year (GAD 2007). According to the Government Actuary's Department projections, the number of older people aged 65 years and over in the UK is expected to increase from 9.7 million in 2006 to 15.5 million in 2030, an increase of 60 per cent. On the basis of the above dependency care ratios, the number of care workers and nurses in older adult care would need to rise to 1,025,000 and 96,000 respectively by 2030.

The third part of the model estimates the breakdown by UK and foreign born workforce required on the basis of low, medium and high assumptions in relation to foreign born carers. The low, medium and high scenarios are then as follows:

- *low scenario*: the base year number of foreign born carers is kept constant throughout the projection period;
- *medium scenario*: the base year percentage of foreign born carers is kept constant throughout the projection period;
- *high scenario*: the base year number of UK born carers is kept constant throughout the projection period.

Essentially, the low scenario assumes that the future additional demand for care work has to be met entirely by UK born workers; the high scenario that it has to be met entirely by foreign born workers; and the medium scenario that foreign born workers have to contribute to the expansion of the care workforce to the same extent they are contributing at the beginning of the projection period.

To check the robustness of our results, the dependency care ratios for care workers and nurses were also calculated in a more sophisticated way, i.e. considering as care users only older people (65+) reporting difficulty or requiring assistance with at least one activity of daily living (ADL). These numbers were estimated by five-year group using data from the General Household Survey. Assuming constant ADL indices across the projection period, the number of older people in need of care was projected to increase from 1.6 million in 2006 to 2.7 million in

2030. In relative terms this was only slightly higher than the growth rate of the overall older population (69 per cent), leading to only slightly different results for our three scenarios.

Care projections (whether number- or cost-based) are obviously sensitive to assumptions about the future development in age-specific disability rates (e.g. Rothgang et al. 2003; Karlsson et al. 2005). Therefore, within the scope of the ADL-based care ratios at base year, an additional projection was made incorporating annual decreases in the base year age-specific ADL disability rates corresponding to the observed decreases in these rates from 1994/5 to 2001/2. Results showed that a decreasing prevalence of disability would reduce the number of carers needed to maintain care provision at its current intensity, but would not change the overall trends – i.e. a significant expansion of the care and nursing workforce would be needed anyway.

Appendix 6. International Advisory Board and Project Team

A6.1 Advisory Board

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