



KALAYAAN
justice for migrant domestic workers



Care and Immigration

migrant care workers in private households

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September 2009



LOTTERY FUNDED

This research was conducted by Kalayaan in collaboration with Dr Bridget Anderson, Centre on Migration, Policy and Society (COMPAS), University of Oxford

Acknowledgements

We gratefully acknowledge the funder of this project, the Big Lottery Fund, without whom this project would not have been possible.

Our deepest thanks go to the advisors on this project: Dr Bridget Anderson, Rita Gava and Kate Roberts for their invaluable support. We would also like to thank Kalayaan staff members and volunteers and, in particular, Jennifer Moss, Camilla Brown, Margaret Healy, Dita Niyogi, Elaine Garcia and Abigail Yao for their assistance during various stages of the project.

Our warm thanks go to the Advisory Board of this project and those individuals who provided insight into the issues raised within the report: Annette Baines and Christine Eborall (Skills for Care), Clive Newton (Age UK), Nick Clark (London Metropolitan University) and Gill Vickers (expert on personalisation of care).

We would also like to acknowledge Jennifer Newman and Vanessa Hughes for their superb graphic design and layout work and Karin Heissler for editing this report.

Finally, we would like to thank all the migrant care workers and agencies who gave their time for the interviews which are used within this report.

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Table of Contents

Introduction: Who are migrant care workers?	7
Synopsis	7
Background: Kalayaan	7
Migrant Domestic Workers (MDWs)	8
Migrant Care Workers (MCWs)	8
The phenomenon of migrant care work in the private home	10
Objectives and aims of this report	11
Methodology	12
Overview of the report	13
Section 1 Living and working conditions	14
Hours of work	15
Training and skills	17
Accommodation and food	18
Isolation	19
Section Two -How do migrant care workers negotiate their employment and social relationship with the care user and their relatives?	21
Introduction	21
Contractual status	21
Loving and leaving: the power to change employers	24
Social relations	26
Skilled nature of domiciliary care work	29
Personalisation of care	29
Conclusion	31
Section Three: How does race and racism impact on the employment of migrant care workers?	32
Introduction	32
Discrimination at the point of entry into care work	32
Discrimination experienced within domiciliary care work	34
Migrant care workers' perceptions of employers	35
Racism in private households: who is to blame?	36
Conclusion	37
Section Four: Recommendations	38
1. Making migrant elder care workers visible	38
2. Personalisation of care	38
3. Employers	39
4. The need for care plans	39
5. Training	40
6. External support	40
Conclusions	41
References	42
Appendix: Descriptive statistics	45
Chart One: Accommodation	45
Chart Two: Country of origin	45
Chart Three: Gender	45
Chart Four: Number of children	45
Chart 5: Immigration status	46

Introduction: Who are migrant care workers?

Synopsis

From January 2007 to October 2009, the London-based charity Kalayaan embarked on a research project to investigate the role of migrant domestic workers employed to care for the elderly in private households. The research –done in collaboration with the Centre on Migration, Policy, and Society (COMPAS) at the University of Oxford, and funded by the Big Lottery Fund (BLF) –explored the living and working conditions of migrant care workers caring for the elder, and covered broad areas such as employment relations, care regulation, race and racialised labour, integration, and skills. It explored the following research questions:

1. What are the living and working conditions of MCWs?
2. How do MCWs negotiate the employment and social relationship with the care user and their relatives?
3. How does race and racism impact on the employment of MCWs?
4. What strategies are helpful in promoting the inclusion and providing greater support for MCWs?

Findings arising from the study are of relevance in the fields of both care and integration. They also provide migrant organisations, trade unions, and related charities with information that will help them to reach out to and support this invisible but growing workforce within the social care sector.

Background: Kalayaan

Kalayaan (which means 'freedom' in Tagalog, the Philippine language) is a support and advocacy organisation that works to improve the quality of life of migrant domestic workers and support their social inclusion. Kalayaan was founded in 1987 as a campaign group aiming to change the immigration policy and practice that tied migrant domestic workers to their employers, even in cases of extreme abuse and exploitation. The campaign was won in 1998, but Kalayaan's services were still needed as migrant domestic workers continued to face discrimination, abuse, low pay, and long working hours. Kalayaan gives advice on all these issues, plus training in areas such as how to access healthcare, employment rights, immigration, English for speakers of other languages (ESOL), and basic vocational skills.

Advocacy work is also still required, particularly in areas such as the retention of passports by employers and the payment of minimum wage. Kalayaan also provides practical emergency assistance to clients who have recently left abusive employers (for example, in the form of short-term housing, small grants and clothes).

Kalayaan's clients come from over 30 different countries, and 93 percent are women aged between 19 and 59 years old. Around 450 new workers approach Kalayaan each year, and services are provided to around 3000 people. Kalayaan carries out media work and attends local, national, and international events to enhance its public profile. The organisation is registered with and regulated by the Office of Immigration Services Commissioner (OISC), and has been awarded the Community Legal Services Quality Mark for having achieved specified standards in delivering advice services. It was granted charitable status in 2003.

Migrant Domestic Workers (MDWs)

The International Labour Organization (ILO) defines 'domestic work' or 'domestic workers' as those who "organize, carry out, and supervise housekeeping functions in private households with or without the support of subordinate staff."¹ These functions include:

- (a) supervising workers employed in households as domestic staff;
- (b) purchasing or controlling the purchase of supplies;
- (c) controlling storage and issue of supplies;
- (d) *assisting in cases of minor injury or illness by performing tasks such as taking temperature, giving medicine, putting on bandages [our emphasis];*
- (e) sweeping, vacuum cleaning, washing and polishing floors, furniture, and other fixtures;
- (f) making beds, cleaning bathrooms, supplying soap, towels, and related items;
- (g) taking care of household pets and plants, receiving visitors, answering telephones, delivering messages and shopping for groceries;
- (h) preparing and cooking meals, setting and clearing tables and serving food and beverages;
- (i) cleaning kitchens and generally helping with kitchen work, including dishwashing.²

These duties generally fit the description of the basic duties performed by the migrant domestic workers seen by Kalayaan. Although it does not capture the extra duties that workers are asked to perform, such as looking after children, looking after neighboring properties, or, as this research will show, looking after elderly or disabled individuals living within the household.

In this report we use the term migrant domestic workers (MDWs) to refer to overseas domestic workers who enter the UK with a "migrant domestic worker visa." They must enter the UK accompanying their employers or a member of their employer's family, but after entry they are able to change employers in the case of abuse or exploitation. At time of writing, the visa is renewable, and after five years workers are eligible for settlement. However, the changes in the UK government legislation, specifically the introduction of the Points Based System (PBS) -- which is designed to admit workers only if they have a certain number of qualifications -- together with new Citizenship legislation enacted in 2009, mean that these hard won rights are likely to change in the next few years.

Kalayaan figures and research have demonstrated that MDWs frequently suffer from abuse (sexual, physical, and emotional), discrimination, low pay (or none), exceptionally long working hours, social isolation, and mental health problems arising from the extreme conditions of their employment. Many experience very poor working conditions, such as having to sleep on floors and not being provided with bedrooms, and being given no time off, sick pay or access to healthcare.³

Migrant Care Workers (MCWs)

The ILO likewise defines care workers as those who "provide routine personal care, such as bathing, dressing, or grooming, to the elderly, convalescent, or disabled persons in

1 International Labour Organization (2008) *Draft ISCO-08 Group Definitions: Occupations in Cleaning and Housekeeping. Updating the International Standard Definition of Occupations (ISCO)*.

2 *Ibid*, p.4.

3 Oxfam (2008) "New Bonded Labour? The impact of proposed changes to the UK immigration system on migrant domestic workers," Report produced in collaboration with Kalayaan.

their own homes or in independent residential care facilities.”⁴ These include:

- (a) maintaining records of client care, condition, progress, or problems, reporting and discussing observations with supervisor, or referring concerns to appropriate nursing, medical or social service workers;
- (b) helping clients to move in and out of beds, wheelchairs or vehicles, and with bathing, toilet, dressing and grooming;
- (c) providing patients and families with emotional support and instruction in areas such as caring for infants, preparing healthy meals, living independently, or adapting to disability or illness;
- (d) changing bed linen, washing and ironing patients' laundry, and cleaning patients' quarters;
- (e) entertaining, conversing with, or reading aloud to patients to keep them mentally healthy and alert;
- (f) planning, purchasing, preparing, or serving meals to patients or other family members, according to prescribed diets;
- (g) ensuring that persons take prescribed medication at the right times and assisting them with their medication if required.⁵

In the United Kingdom, many of these above tasks require specific skills and knowledge, and are all in the national induction standards. Some skills require certificates of competence, for example in moving and handling elderly or disabled persons, or in food hygiene or the administration of medication.

In this report, there is an overlap between MDWs and MCWs, as many MCWs are, in fact, migrant domestic workers who entered the UK through the domestic worker visa. But not all MCWs entered on this visa; others include those who are on ILR status and student visas. Our sample of MCWs also includes a handful of careworkers who are not subject to the same immigration controls (i.e. MCWs from Poland).

In spite of the significant number of migrant workers occupying the British adult social care sector, there is no specific visa category for migrant workers who provide care to elderly employers in private households. Indeed, the introduction of the PBS has given rise to some considerable challenges in the eldercare sector⁶. The paid care workers referred to in government and public policy are those who work for statutory or independent-employers or employment agencies.

By 'migrant care workers', this report refers to migrant workers who provide care to elderly employers in private households; they may be on varying visa statuses, including as MDW, student, Indefinite Leave to Remain, undocumented, or dependent (i.e. as a spouse). Although a large number of MCWs interviewed for this project were on migrant domestic worker visas, several had held various immigration statuses. Because of the domiciliary nature of their work, MCWs experience many of the same abuses as MDWs, both physical and psychological.

⁴ International Labour Organization (27 April 2009) *Draft ISCO-08 Group Definitions: Occupations in Health. Updating the International Standard Definition of Occupations (ISCO)*.

⁵ *Ibid.* p.64.

⁶ Migration Advisory Committee Report, 29 April 2009. Report available here: <http://tinyurl.com/nh6fwe>

The phenomenon of migrant care work in the private home

Kalayaan caseworkers have long observed that there have been increasing numbers of migrant workers being employed to care for the elderly in private households. Paid care for the elderly is a growing phenomenon across the European Union (EU), and the UK is no exception.⁷ CSCI data from local authorities reported a total of 73,540 recipients of direct payments in England in March 2008, of which 64,850 were for older people aged 65+ and adults aged 18-64.⁸ This government-licensed body also estimated that roughly 145,000 elderly people were funding their own personal care in 2006.

The reasons for this are complex, encompassing the privatisation and marketisation of care, the ageing population, and other economic and social changes.⁹ Some attention has been paid to the gendered implications of this, and the reinforcement of income inequalities that it generates.¹⁰ There is, however, a lack of information and analysis on what these changes mean for migrant workers, the potential demand generated for migrant labour and the living and working conditions of MCWs. While the existence of a significant number of MCWs has been recognised in other European countries such as Spain and Italy, both of which issue specific visas for this type of work, this is not the case in the UK.

Research on migrant domestic workers in the UK has tended to focus on those caring for children.¹¹ The little research available on migrant elder care that has been conducted in the UK has tended to focus on migrant nurses in the National Health Service (NHS), and on MCWs working in care homes.¹² While this work does cover an important phenomenon in social care, Kalayaan caseworkers believe that migrant workers are now playing an unrecognised role in providing elder care in private households as well. This project was inspired by the lack of research in this area, which seems all the more pressing given the government's promotion of direct payment for care. While the take-up by care users is currently low, if this continues to be promoted as empowering care users, then the rights of care workers in general, and of migrant workers in particular – especially given their vulnerability to exploitation – need to be recognised and expressed to policy makers.

Currently, migrant care workers are neglected in terms of support services specifically tailored to their needs. Although several carer organisations offer support and services to unpaid carers¹³, paid migrant care workers are not included in their client group, despite sharing many similar problems with unpaid carers. Migrant workers caring for children can meet other carers when taking children to schools, clubs, or play areas, and are thus able to socialise and share important information. However, those caring for the elderly are often far more confined to the house and therefore are less likely to have opportunities for meeting other people, accessing services or gaining information about their rights. In addition, the work is often physically difficult, and the emotional demands made of those who are caring for older people with dementia, or for people who eventually die, can be exhausting and traumatizing. Moreover, the relationships between the care worker,

7 Yeandle, S., Gore, T., Pickford, H., Stiell, S. (1999) *Employment in Household Services in the UK*. Dublin: European Foundation for the Improvement of Living and Working Conditions.

8 Skills for Care (2008)

9 Van Eyck, K. (ed). (2005) *Who Cares? Women Health Workers in the Global Labour Market*. Public Services International: UNISON UK.

10 Ungerson, C. (2004) Whose empowerment and independence? A cross-national perspective on 'cash for care' schemes. *Ageing and Society*, 24, 189 – 212.

11 Anderson, B. (2000) *Doing the Dirty Work: The Global Politics of Domestic Labour*. London: Zed Books.

12 Bach (2006), Buchan (2002), Buchan (2003), Buchan et al (2003), Kingma (2003), Winkleman-Gleed (2006)

13 The Princess Royal Trust for Carers, Crossroads, Carers UK, Black Carers Support Group, among others.

the care user, and the person paying for care often require complex negotiation. When the person paying for care is a relative of the older person, conflicting demands may be made of the carer by different parties. Questions of race further complicate this.

Kalayaan believes that MCWs have specific advice, service, training, and development needs that are not being met. There is a requirement for a more thorough exploration of the extent of this phenomenon of migrant care in the private home, which this project seeks to address. The research findings of this project will be used by Kalayaan to empower and support this group, and to begin advocacy work that will highlight and change the situations that migrant care workers find themselves in. Through these findings and recommendations, the organisation will be enabled to develop strategies for promoting inclusion of migrant domestic care workers within Kalayaan, other groups, and wider society. This research will furthermore allow an opportunity for formal liaison with policy makers to ascertain thinking on current policy issues and ultimately feed into policy development. Raising the profile of migrant care workers will impact positively on the profile of other groups of care workers, and networking between relevant groups will open and widen the debate and ensure good practice is shared. Likewise, ensuring that care workers are able to provide care in safe, well managed conditions will have a great impact on the type and quality of care provided to care users.

Objectives and aims of this report

MCWs who care for the elderly have thus far been neglected in terms of specific services, both those offered to migrants by migrant organisations, and those offered to unpaid carers. In Section Four, this report includes a detailed list of recommendations and best practices for increasing the social inclusion of MCWs and planning for future services to support them. This will make a long-term difference by ensuring that migrant care workers are specifically included in Kalayaan's work and campaign agenda, and issues are raised with similar organisations, service-providers, employers, and policy-makers.

The research process in itself provided an opportunity for MCWs working with the elderly, often isolated, to meet and share experiences. Throughout the research period, information and workshops on practical issues (such as accessing employment rights, equal opportunities, healthcare, and pensions) were held, so as to ensure that the research was not a one-way process, but also a means by which MCWs would likewise be able to benefit immediately. The ultimate objective of this report is that MCWs are eventually offered appropriate support based on their particular needs and situation.

This report provides information about migrant workers who care for the elderly, and what their living and working conditions are. As well as wages, hours of work, accommodation, and employment contracts, this also includes more qualitative issues such as how the employment relationship is negotiated between a MCW and a care user or the care user's families. Understanding this relationship can be useful in developing tools that can enable MCWs to better negotiate with employers and care users alike. The recommendations keep in mind that, because this relationship takes place within the private household, it is important to maintain a balance between regulation and state intervention on the one hand, and the right to a private life on the other.¹⁴

This report broadly covers the following areas:

- The challenging aspects in the employment of migrant care workers, in particular

¹⁴ Olsen, F. (1983) *The Family and the Market: A study of ideology and legal reform*. *Harvard Law Review*, 96, 7, 1497-1578.

- a) physical tasks; b) the relationship between care workers, care users, and relatives, and; c) the impact of race and racism on elder care;
- The commonalities and differences among MCWs in various employment situations (live-in and live-out), and;
- Recommendations for a community-based strategy targeted at carer groups, support services, and policy makers.

Methodology

Data was collected through a series of in-depth semi-structured interviews with 50 migrant care workers.¹⁵ MCWs were drawn from a variety of sources. The first initial interviews were collected from Kalayaan clients who were caring for elderly people. Ten migrant care workers were drawn from COMPAS, from a similar project on migrant care work (see Cangiano et al., 2009), and the rest were drawn using the ethnographic method of snowball sampling. MCWs interviewed pointed us out to their friends and other informal groups who were doing the same type of work, until a total of 50 interviews were gathered in all.

Descriptive statistics of the interviewees, are provided in the appendix (which appears at the end of this report). All interviewees were either caring for an elderly person as paid work, or had experience in paid eldercare. Most interviews were conducted in English by trained interviewers with experience in communicating with people for whom English is a second or third language. A few interviews were conducted in Hindi and Filipino. Each MCW provided their informed consent, either written or orally, before the interview took place. All interviews were recorded. Interview questions covered the type of work performed, employment and social relations with care user and relatives, and experiences of services offered to them (if any).

The interview format was designed in consultation with the research project's Advisory Board, made up of Kalayaan Management Committee members, and agency, academic, migrant organisation, and MCW representatives.

The interview focused on the following research questions:

1. What are the living and working conditions of MCWs?
2. How do MCWs negotiate the employment and social relationship with the care user and their relatives?
3. How does race and racism impact on the employment of MCWs?
4. What strategies are helpful in promoting the inclusion and providing greater support for MCWs?

Findings from each research question are discussed in detail within each section of this report.

Employers of MCWs were also interviewed, as well as representatives from Help the Aged and the Social Care Association and 10 private agencies who supply care workers. These interviews were conducted in order to provide a more general overview of the market for elder care.

¹⁵ Ten (10) migrant care worker interviews were sourced from data gathered by the Centre on Migration, Policy, and Society (COMPAS), as part of a collaboration with the COMPAS project by Cangiano, A., Shutes, I., Spencer, S., Leeson, G. (June 2009) *Migrant Care Workers in Ageing Societies: Research Findings in the United Kingdom* COMPAS, Oxford. Full report available here: <http://tinyurl.com/lm9jty>

Overview of the report

The first section of this report covers the general living and working conditions faced by MCWs, scrutinizing what life and work are like behind the closed doors of the private household. It examines issues of accommodation, food, hours of work, daily skills and tasks required, skills training, administration of medication, physical demands (including lifting), and loneliness and isolation.

The second section traces how MCWs negotiate their employment and social relationships with their care users and families. It also takes a brief look at MCWs' social networks in general. Questions and issues that are examined closely include, who are considered MCW 'employers' in the complex relationship between elderly care users and their families, the personalised relationship between care users and MCWs and how this impacts on the employment relationship between the two, the relationship between MCWs and their care user's families, the link between immigration status and MCW's negotiating power, and contractual issues.

The third section explores the contentious issue of how race and racism impacts the employment relations of MCWs. It examines discrimination at point of entry into care work, racial stereotyping among MCWs, care users, and their families, differences in wages, discrimination on the job, differential treatment according to race and nationality, and perceptions of race and racism among MCWs and care users. The analysis draws heavily from employer and agency interviews, in addition to MCW responses.

The final section provides a comprehensive list of recommendations for MCWs based on the analysis. It includes recommendations on regulation, citizenship, training, health and safety laws, and social inclusion, among others.

Overall, this full examination of the role of migrant care work in the UK, and the policy recommendations stemming from this, go beyond the current analytical paradigm which focuses solely on rigid and fixed notions of skills, demand, and immigration status, and places more emphasis on the relationship between care users and care workers in the pedagogy of everyday life.

Having set the context in which this report was prepared, in the following section, a discussion is provided on the general living and working conditions experienced by MCWs.

Section 1 Living and working conditions

The unique position MCWs occupy within the social care system is shaped by three distinct factors. First, in spite of the numbers of migrants providing care for the elderly in private households, the term 'migrant care worker' does not exist explicitly in current policy or health and safety law, or as an immigration status. This is despite the fact that it is generally acknowledged that migrant workers do occupy a visible place within the social care sector.

The term "carer" is typically referred to as "anybody who looks after a family member, partner, or friend because of their illness, disability, or frailty. All their care is unpaid."¹⁶ Sometimes the term carer can also include someone who provides paid care to patients in a hospital setting or nursing home.¹⁷ Likewise, workers who provide paid care within a domiciliary setting are "care workers," given that they are managed and provided by a care agency, local council or employed privately¹⁸

Second, employment law states that it is illegal for employers to discriminate against workers on the basis of sex, nationality, race, color, disability, religion, sexual orientation, or age. But jobs that involve working for an employer in a private household, such as care and domestic work, are exempt from this.¹⁹ And although the Health and Safety Commission provides guidelines for the safety of migrant workers, care workers in institutional settings, and health workers in general, it falls silent when it comes to specific provisions protecting paid care workers working in private households not hired by agencies. Also, employers in private households are not subject to regulatory checks performed by the CQC.

Third, immigration restrictions ban MCWs from attending training courses such as the National Vocational Qualification (NVQ) levels 1 – 3, which provide standardised and certified training in care. NVQ courses leading to certification are open only to British citizens, those with settled immigration statuses or those who have been in the country for more than three years. Migrant care workers can attend these courses, provided that they are capable of paying the full, non-government subsidized price. However, an NVQ qualification cannot be attained. This not only poses a danger to care workers, but to care users as well.

Much care work involves specific skills, such as the dispensation of medication, the administering of injections, food hygiene, and the proper and safe use of medical equipment (such as hoists and wheelchairs), particularly when caring for a very frail elderly care user. MCWs are placed in a position where they are forced to provide these services without having any official training or professional assurance.

These three factors help create conditions which place migrant care workers in a particularly vulnerable position, subject to exploitation by care users, and isolated both socially and legally as a sector. Interview findings reflect how these restrictions and gray areas in policy affect migrant workers' living and working conditions.

In addition to these institutional challenges, the care sector itself is a heavily feminised one, gender being a significant factor impacting the living and working conditions among

16 NHS Choices website, *What is a carer?* <http://www.nhs.uk/CarersDirect/carerslives/Pages/Whatisacar-er.aspx>

17 Health and Safety Commission, *Better Regulation: Regulatory Bodies Inspecting Social Care*. <http://www.hse.gov.uk/lau/lacs/23-21.htm>

18 *Ibid.*

19 Race Relations Amendment Act (2000).

MCWs. What is traditionally considered 'women's work', which is both low paying and low status, is occupied by migrant women who typically come from poorer countries and who are therefore placed in a double bind. Not only does their marginal status as low-skilled migrant women severely limit their access to the labour market, but also by occupying low status and poorly paid jobs, their marginality is further exacerbated. This makes them even more vulnerable to various kinds of employment abuses.

Hours of work

The following workday scenario is an amalgamation of various migrant care workers' descriptions of their typical 'work routine':

A working day for a migrant care worker may begin from anywhere between 6:00 to 7:30am, when the worker wakes. Assuming she lives with her care user, (CU) she will wake her CU, who will then be led through morning exercises, bathed and changed, then lead to the kitchen, where the worker will begin to prepare the CU's breakfast. Morning medications may be dispensed at this time. Likewise, the CU may use this time to chat with the worker, depending on how talkative or how informal their relationship may be. Afterwards, a worker may lead the CU to the living room to perhaps listen to music, read, or watch television. While the CU does this, a worker may resume her affiliated domestic duties, such as washing up, changing the bed linen, ironing, scrubbing the floor, or cleaning the bath. In between all this, a worker may suspend her domestic work to offer her care worker tea and biscuits for elevenses. A worker may then begin to prepare lunch around noon, and lead her ward from the living room to the kitchen table again for mealtime. Medications may be administered at this time as well. After lunch, many care users nap, during which time care workers may continue household chores, including grocery shopping or Hoovering. They may then begin to prepare tea, then dinner, and lead their employers to the kitchen for the final meal of the day. They may then lead the care user back to the sitting room to relax which she cleans up around the kitchen. Afterwards she will help her employer wash up and prepare for bed. A workday can end any time from 10pm onwards.²⁰

Although this typical workday scenario seems straightforward, and even serene, it does not capture the variety of situations that migrant care workers find themselves in, given their varying work arrangements, immigration statuses, and the mental states of their elderly employers.

In fact, for several migrant care workers in our sample, it was the first time that they had been asked to break down their days into a describable routine. Some found it difficult, insisting that every day was very different. A characteristic inherent to care work is that it is that it is both highly unpredictable and changeable, and not easily subject to time blocks or 'work shifts'. Strict time shifts, wherein specific care tasks are dispensed within a specific block of time, are possible in residential care settings where there are several care workers on rotation. But in a private household, where a migrant care worker is given sole responsibility for her elderly employer, need takes precedent over all other duties. This was often buttressed by the employer's expectations that their migrant care workers be 'on call' at all time. This includes care undertaken at night for elderly employers who wake constantly. This work is done during what is supposed to be the migrant care worker's sleeping hours. One interviewee recalls,

²⁰ This scenario is an amalgamation of various MCWs' descriptions of their typical daily 'work routine.'

I can sleep night until 10.30...[then] I wake up. I'm waiting for him. But I can sleep. Maybe I'm [sleeping] soundly...he's coming. I'll quickly wake up. I make him tea, everything. Some[times] 2 o'clock, 3 o'clock, 4 o'clock [in the morning] he is calling me. I'm not taking my sleep. I'm think[ing] for him (C9).

According to another,

You know, I enjoy [care work], but, you know, [I'm] on my own 24/7, around the clock...[I]n the nursing or residential...they have shifts, you know, work from certain time to certain time. For me, I don't have [that]...I have to do midnight, [or] not midnight, you know? There's so much I have to do (C42).

Another migrant care worker, who was promised a daily two-hour break by her employer, found out that taking a break was impossible, and could even lead to neglect. Fear of leaving their elderly employer alone sometimes resulted in the workers feeling unable to leave the house during these designated rest periods:

Sometimes you can go out, because they [the employer] say you can go out. But with this lady, how can you go out when she's [constantly] falling like that? You [should be able to] do what you want with your two-hour break, isn't it? But [her falling constantly] means you should be with her [instead]. It's difficult now. How can I take my two-hour break? (C37).

Significantly, when their employer's health declined, workers were expected to work without breaks, staying with their employers at the hospital or at their bedside, usually without any additional pay for extra travel, overtime, or night work:

[The] few hours I had off on Tuesdays, Wednesdays, Thursdays, that's when I'd do my course for my grammar. But as soon as I finished, I am coming, running [back to the employer's home]. So I stopped coming...because I don't want to take more than two hours away [from my sick employer]...So all the time I was like a dog, running and turning and serving all the time (C8).

With regards to the case above, as it happened without warning, the migrant care worker found herself ill-prepared both emotionally and physically to deal with this change.

Another factor that makes the provision of care in the private home difficult to routinise is that the tasks expected of migrant care workers are often perceived by employers as inseparable from those expected from domestic workers. Care work often goes beyond the actual care user and extends to their living space, but many workers were unaware that their jobs would entail so much domestic work. This, coupled with the fact that many migrant care workers are holding "migrant domestic worker" visas, contributes to the overwhelming sense of performing "two jobs for the price of one" (C37). The problem is that the physical labour of care is difficult, if not impossible to circumscribe.

Migrant care workers in our sample said that they felt that the excessive household tasks they were performing fell beyond the remit of their original job descriptions, and that there was no clear understanding with their employer where their jobs began and where they ended. As one worker recalled, "It's like I'm their maid. It's like you are doing the housework. It's like you are a maid." (C1) She continued,

I don't know...they said it's only a carer job. I thought that someone [additional]

maybe coming to help the family [home], like cooking and cleaning, but [the employer] tried to manage with us only. That's what happened. So we would be much tired, doing this work and that work (C1).

Workers note that because they are in a one-on-one situation with their employers in a private household, many times employers have felt entitled to include unrelated household tasks as part of their job:

They want to make you work for every penny they pay you. That's how you get into a situation where you have to clean all the windows, the silver, the carpets, just for the sake of doing something rather than for you to sit down and have a bit of a break (C36).

Alongside the responsibilities of caring for a cancer patient, one MCW was also expected to look after the dog and clean a 12-room apartment. This included; dusting, cleaning, covering, mopping, and polishing the silver. "There's too much mopping, cleaning, mopping", (C20) she explained.

One MCW was tasked with looking after the children of her employer's relatives when they came to visit, and also with the following:

...[maintaining the] general housekeeping and following up the bills, appointment to the hospital, payment, like paying things etcetera you know. Because there will be no one to do it so they say to me, the electricity, you have to do those things (C36).

Despite the availability of local council care workers who visit the elderly on a routine basis to provide care services (such as; assisting with movement, basic housekeeping, assisting with changing, basic grocery shopping and chores), several care users and their families choose to hire MCWs to provide around-the-clock care. This suggests that the care provided by local council care workers was not considered substantial enough to fit care user's needs. Indeed, nearly one third of the migrant care workers in our sample reported that they were employed in addition to local council care workers. It is worth noting, however, that care workers provided by local councils still make up a minority of those providing domiciliary care. Most care workers (not including or referring to the MDWs referred to in this study) are provided by independent employers or agencies.

Training and skills

Concerning the more formal aspect of care work, only 30 percent of respondents had participated in some form of eldercare training. This is not surprising given the strict restrictions limiting non-British citizens or permanent residents from undertaking reduced-fee certified care training. Of those respondents who had received some form of training, the majority had been on short one-day or one-week courses and a few had received training in their countries of origin (such as in nursing school or through vocational care worker training, both of which are popular in the Philippines). Four care workers were enrolled or had attained NVQ level qualifications but all of them had been in the UK for several years before having access to this training given the aforementioned restrictions. Finally, a few care workers who are in the UK on a student visa, had been provided with a little training (for example first aid). However, it is unclear whether this training provided by the 'schools' they are affiliated with (which in some cases function as employment agencies) meets the national standards, or if the training results in actual certification.

The majority of respondents learned on the job, either from their employers, or their employer's families, nurses, GPs, health visitors or friends. Migrant care workers who look after employees with severe physical or mental disabilities are often expected to be familiar with the correct use of nursing aid equipment such as hoists, wheelchairs, and walkers, in spite of having no previous experience or training in specialised care. In these cases, care plans which fully outline the condition of the care user, and include a risk assessment and daily routine would be particularly useful.²¹ Among the households that are not equipped with these aids, the MCW is expected to bear the extra physical toll of care work. This places both the care user and the care worker in a dangerous situation, as injuries can occur easily.

A significant number of migrant care workers highlighted their concern that the lifting element of their job might be damaging their backs. This was particularly a concern for smaller MCWs who were required to lift care users who were substantially heavier than themselves. One MCW, who weighs 49kgs and is 5'1", works with a care agency and cares for several elderly clients on a live-out, hourly basis. She reflected on one employer in particular:

Sometimes when we have to assist her, like when she has a hard time standing up...sometimes you just have to force [her to stand]...and it really hurts my back. It's not that she's heavy, it's just that she can fall all of a sudden. She'll just say, "I'm going down!" And then she falls straight down. Sometimes she forces it, and we have to be quick to catch her. (C33)

She further explained, "Our clients are not only old, they're fragile too. And we need to constantly assist them. You need to help them stand. So [I] worry what it's [all] doing to my back."

Lifting is but one of the many things that MCWs do which duplicates the tasks performed by certified nurses, care workers, and primary care workers. Several respondents indicated that not only did they administer medication, but also they prepared it and arranged for refills with the pharmacy. In addition, respondents mentioned that they administered catheters and injections for diabetes. Although a few said they were shown how to do this by a nurse or doctor, none of them had any formal training in this otherwise.

Accommodation and food

Many migrant workers preferred live-in accommodation because it helped them save on the high costs of private accommodation, the costs of transportation, and the time spent traveling to and from work. Also, the preference towards living in was shaped by the care worker's ideas of what 'good care' or a 'good job' entailed. According to one MCW, "It is better to [live-in] because you got to spend more time [with your employer]" (C6).

Those who chose to live-out cited the following advantages: fewer working hours, more free time, increased levels of privacy, and being able to switch off at the end of the day and not having to think about their responsibilities to the care user. As one MCW noted, "I think if you are live-out, it's good because you can have enough rest, you don't think of responsibility when you're out of the house. You have enough...you think of other things" (C10).

Another MCW added, "[The] advantage of living out is [you] work less hours and less time.

²¹ The Health and Safety Executive spells out clear guidelines for risk assessment that must be undertaken by employers expecting employees to do manual lifting in "Manual handling", Manual Handling Operations Regulations 1992 (as amended). Guidance on Regulations L23 (Third edition) HSE Books 2004

When we go out, we socialise with friends. When you're in somebody's house, you're always alone, especially if [you live with] a family" (C2).

It is also worth noting that the choice of living in or out may not be a choice at all, and that MCWs who have recently arrived and who do not have a tangible and supportive social network in the UK may know of no other arrangement other than one that involves 'living in'. Those who have built a network of friends from church groups, community organisations, or colleagues within the same sector may have more choice when it comes to living in or living out, including the possibility of sharing accommodation with social peers. The same goes for newly-arrived migrants who are affiliated with agencies; their living arrangements and working hours may be determined entirely by their care agencies.

Several MCWs indicated that they received insufficient food. This was also raised as a crucial issue within a focus group discussion conducted with care workers. A few of the recruitment agencies interviewed also indicated that food can sometimes be an issue of contention between a care worker and her employee. Specifically, elderly care users often eat very little, and much less than their care workers. However, employers sometimes expected their care workers to eat the same amount as them and refused to shoulder the costs of extra food. To get around this one MCW occasionally commutes home at 3pm to have lunch because of the lack of food provided at her employer's house. "She eats a little," she noted, "so when you eat together you have to expect the same volume the way she eats" (C35).

Agency interviewees have observed that they are aware of the difficulties that MCWs face with food, and have acknowledged that it is a live-in care worker's right to be provided with enough of her own food, especially in cases where a cultural difference exists between an MCW and care user. One MCW mentioned that "whatever is bought there, I eat the same things so nothing special that what I want to eat. Never. Because if I want to cook something they don't like the smell, you know, if you cook something she gets the smell right soon" (C35).

Isolation

Although several organisations offer support and services to unpaid carers, MCWs who are paid to provide care in private households are not included in their client group despite facing similar work problems and isolation. Migrants who look after children have opportunities to see and meet other child minders when taking the girls and boys to schools, clubs, or play areas such as the park. They are thus able to socialise and share information. Migrants who look after older people, on the other hand, are often more confined to the house and are therefore less likely to have opportunities for meeting other people, or for accessing services or information about their employment rights. In addition, as findings from our interview sample show, their work is often physically difficult, and the emotional demands on those who are caring for an elderly employer with dementia, or for an employer who dies, can be exhausting and even traumatizing. As one MCW noted,

It is difficult working as a live-in care[r]; your social life is limited you know? I don't have plenty of time to socialise. You have to do it like only [on a] time table to save...time, like to meet someone. But when you're working in a care home, you see people every day at work. You talk, you laugh. It is more healthy (C49).

Several of the respondents indicated that they had very little free time when performing

full time live-in care and that even when they had breaks it was sometimes difficult to leave their elderly employers alone. ,

Of course I'm lonely. But I'm also thinking [a lot] because I'm alone. Sometimes, he (elderly employer) is also not talking and he's alone. He's also lonely. I'm also lonely...24 hours I'm in the home. I'm doing [this] because sometimes that lady (the local council carer) not coming. I'm in the whole time. I'm not going out (C9).

The majority of respondents interviewed appeared to be members of informal social networks (made up of friends, family, and other migrants), although some were members of more formal networks (such as church and migrant organisations). In spite of these existing networks, MCWs interviewed still reported feeling an increased sense of isolation. Live-in care workers in particular appeared to have very little contact with anyone other than their elderly employers or their employer's relatives due to the all-encompassing nature of their jobs. In cases where the care user was particularly old, physically frail, or sick, MCWs indicated that it was difficult to leave the care user alone, and this sometimes impacted on their ability to leave the house.

It is clear that the unregulated nature of private care in the household can create a situation whereby the MCW is completely subject to the whims of her elderly employer. As illustrated by the various interviews provided above, a number of troublesome issues arise from this arrangement. However, because this employment takes place in the private home, it is equally important that a balance be kept between regulation and state intervention on one hand, and the right to a private life on the other.²² The following section will consider how these challenges are similarly ingrained within the realm of employment and social relations.

²² Olsen, F. (1983) The Family and the Market: A study of ideology and legal reform, *Harvard Law Review*, 96, 7, 1497-1578.

Section Two -How do migrant care workers negotiate their employment and social relationship with the care user and their relatives?

Introduction

Employment relationships between care workers and care users are distinctive, particularly when the care worker is providing live-in domiciliary care. It is helpful to distinguish between employment relations in terms of formal, contractual arrangements between the care worker and the employer (who may or may not be the care user), and employment relations as the social relationship between care worker and care user (and sometimes, as shall be discussed, the family of the care user). This is for the purpose of analysis, but clearly the contractual arrangements and the social relations are related. This is true in all kinds of employment, but is particularly important to this occupation because forging a good social relationship with the care user is often assumed to be part of a care worker's job description and, in this sense, can be an implicit contractual requirement. The extent to which this social relationship is deemed to be important by both care user and care worker is likely to vary from case to case, but what is clear is that for care workers who work in private households, contractual arrangements, social relations and living and working conditions are inextricably connected. Drawing on in-depth interviews conducted with MCWs, this section will first consider the range of formal contractual arrangements under which they work, and then consider the social relationships between migrants and care users and how these interrelate with contractual arrangements to provide a basic typology of employment relationships between the two parties. In addition, it will highlight the potential implications of these contractual issues in the context of ongoing personalisation of care.

Contractual status

There are three main categories of working people in the UK: 'workers', 'self employed' and 'employees'. People working in private households may fall into any one of these categories. The broadest category is 'worker': this includes employees, and also people who work under a contract for services. People who can turn down work when offered, or who employers have told that they will only have work when they are required are often 'workers' (though the area of law is extremely complex). Workers have limited employment rights. People who work through an employment agency are often workers. People who work through employment agencies may also be self employed. 'Employees' are people who are working under a contract of employment and, importantly, the terms and conditions do not have to be written, only agreed between the two parties. Employees have the full range of employment rights.

MCWs interviewed for this report were often unaware of their employment status. For example, one agency home care worker described how, when she joined a new agency, she had no idea she would be self-employed and has experienced considerable insecurity as a result:

I didn't know that's what they do when I applied for the job that you'll be like self-employed, I thought it would be like the other agency, they just give you work, you know? Self-employed means sometimes you don't get a job easily. That's the problem now and you need income. They [the agency] didn't explain to us all about the number of hours. I'll just read the contract very careful now when I go home (C37).

Similarly, another agency home care worker described how, when she first registered with an agency, they gave her the option of either being self employed or employed directly by the agency. She remarked that, “when I first registered, I had no knowledge, they gave me two forms so I have no idea why they opted me for this one” (C39).

The main distinction, as expressed by MCWs, was whether they worked through agencies, or were directly employed, either by the care user or by a member of his or her family. Those who worked through agencies typically had a written contract, while this was less common for those who were directly employed.²³ Agencies can facilitate a highly contractualised employment relationship between the care user and the care worker, resulting in more regulated working hours, pay and tasks. Those respondents who worked for agencies with good employment practices commented how working for an agency provided a degree of protection which working directly for the care user did not. As one MCW explained:

It's good to be employed by an agency. So you know, you get your correct time, everything, you know, systematically. You get your wages also good, you get your hours, you get your day off- everything (C45).

More specifically, some agencies provide their care workers with a list of pre-agreed tasks. This had the effect of preventing situations where care workers were expected or asked to perform additional work as witnessed with other domiciliary care workers. Indeed, one agency home carer commented:

Everything is written in our book what we should do and we shouldn't. The client knows that they shouldn't let me do things that I am not supposed to do. As a human being, you have to be flexible...But I think my agent is very strict. I don't think there is any type of thing that I'm doing that I shouldn't (C38).

Interviews with agency home care workers also revealed that some agencies regulate breaks and payment for night care. One MCW commented that if she was not able to take her break as agreed with the agency, then the client had to authorise payment for the additional time worked.²⁴ If the client refused to do so, then she had to take her break. Meanwhile, another respondent stated that she had to keep a record of all the times that the care user woke her during the night for assistance, and that she started to receive payment on the fourth call made by the care user each week.²⁵

In practice, the regulating impact of the agency is dependent on the individual practices of the company, and these can vary significantly. In cases where poor employment practices are applied, agency home care workers experience significant insecurity. The extent of this vulnerability is sometimes, although not always, related to whether the worker is employed by the agency directly or is self-employed. Several MCWs complained of difficulties in obtaining their annual leave entitlements. In addition, some agencies appear to take advantage of the job insecurity which surrounds agency work by withholding work from those care workers who complained or refused to complete additional work beyond the agreed tasks.²⁶ Similar practices were employed when it came to working hours. One care worker commented how good agencies would let you know a week in advance what hours you would be working, while with her current agency she would

23 Only four of those care workers employed by the care user described having a written contract.

24 Interview with Filipina agency care worker

25 Interview with Zimbabwean agency care worker

26 Interview with domiciliary care worker, C37.

never know whether she was working the following day.²⁷ Similarly, another indicated that her agency would call her randomly and ask her to work. Sometimes, this would happen just after she had finished a shift. She said that she felt the need to accept the work because of the insecurity that accompanies agency work as well as the expectations of the agency itself. Agencies are thus able to take advantage of the insecurity associated with this type of work by applying pressure on workers to take on additional shifts at short notice. It should be noted that these are issues faced by all agency workers, including British workers, but they are particularly difficult for recently arrived workers to negotiate.²⁸

For those who are employed by the care user or the care user's family, the range of contractual arrangements is even more complex. While written terms and conditions may be supplied, what is required may be very different. MCWs indicated that they were frequently expected to carry out significant amounts of domestic work in addition to care work which led in part to the 24 hour nature of the job. In some cases, MCWs described significant discrepancies between the hours and tasks they were contracted to work and those they were actually expected to work:

I don't know maybe, they said it's only a carers job, I thought that someone maybe coming to help the family, like cooking and cleaning, but she tried to manage with us only. That's what happened. So we would be much tired, doing this work and that work... (C1).

They will say light housework, like this thing. They'll say five days working but I'm working six days. You cannot say that two or three hours I'm working. I'm working full time... (C11).

Some respondents also indicated that performing live-in care work led the employer to believe that they should be on call or available to work at all times without extra pay:

I'm just doing my job. But also I need time to myself. Even if I'm living with them 24 hours, it doesn't mean I should be working every minute. It depends on the client. Some clients will be demanding. They want, maybe they want to sit with you all the time. They want to know what you're doing every minute. They think when you're working for them 24 hours, you should be working all the time (C40).

Payment for night care is a particularly problematic area. Several respondents described how they were woken up by the care user during the night and expected to provide care without additional payment. The Department of Health's National Minimum Standards for Domiciliary Care makes no mention of night care. This is largely related to the fact that domiciliary care work takes place within the private sphere and, as a result, there has been considerable reticence to regulating it appropriately. Respect for domestic workers' rights to work reasonable hours needs to be married with a realistic assessment of an employer's need for a caregiver. Regulation of working hours, in particular the need for a maximum working week with the possibility of paid overtime and regulations over night pay, are crucial in order to move away from the current situation where live-in domiciliary care workers are often called upon to work extremely long hours with no overtime pay. As Adele Blackett (1998) has pointed out, some countries have attempted to creatively combine maximum working hour protections with limited "on-call" duties to try to arrive at fair and realistic solutions to regulate working hours. She highlights the

27 Interview with domiciliary care agency worker (C44)

28 Interview with domiciliary care agency worker (C33)

French CCN as one such example which stipulates that caregivers who are repeatedly called upon during the night for several nights must be remunerated for the hours during which they hold on-call responsibilities. These hours are considered “heures de presence responsable” and are to be paid at a rate that is not less than two thirds of the standard salary. In addition, 25 percent of those hours are to be remunerated at the full rate even when all of the day time responsibilities are not being fulfilled.²⁹ The need for such regulation should not be underestimated both in terms of safeguarding care workers from exploitation, and with regards to ensuring an optimal level of care provision.

Direct employment for live-in care work also raises the question of whether the worker is considered *for contractual purposes* as part of the family. Under national minimum wage legislation, “family workers” are not entitled to the minimum wage. A family worker must live-in, be treated as a member of the family and, in particular, not have the cost of accommodation or food deducted from his or her wages. While this might be the case for many domestic workers, an interesting judgement in 2002 clarified that it is necessary for a “family worker” to share in both the leisure and work activities of the family. An Indian woman (who was on a domestic worker visa) took her employing family to court to demand payment of the minimum wage, which they refused to do because they claimed they treated her as part of the family. The judgment, which found against the family, hinged on what being “part of the family” actually included. It was found that “had the Applicant been treated as a member of the family there would have been many more photographs of her with the family”. It was also noted that when she was included in photographs, she was either in the background or with the child that she was caring for.

Loving and leaving: the power to change employers

Written terms and conditions are generally thought to be an important benefit to workers in employment relationships, particularly when they have limited knowledge and awareness of employment rights. However, an interview with a Community Advocate at Kalayaan confirmed that, while the overwhelming majority of new clients that come to the organisation have little or no knowledge of their formal employment rights, they were also wary of contracts. Furthermore, they tend to view them as an obligation to fulfil rather than as a means of protection:

This does not mean that they have no idea that rights exist, but rather that when they think about employment rights these tend to be more basic and universal in nature, for example the right to respect from their employer and the right to justice, rather than tangible employment rights. Similarly, if domestic workers are given a contract to sign that outlines their working hours and salary, they will sign it. However, they don't really see this as reciprocal, they don't see it as a form of protection for themselves but rather they interpret the contract as a symbol that they are beholden to their employer. I find that it's exceptional for a domestic worker to be aware of the national minimum wage if it's their first visit to Kalayaan. Again, they don't think about it in terms of a national minimum wage but rather in terms of a relative salary to what others are being paid (Interview with Community Advocate, Kalayaan).

In this respect MCWs are similar to migrants working in many other sectors, who often regard contracts, not as a means of enforcing rights, but as giving employers increased

²⁹ Blackett, A. (1998) Making domestic work visible: the case for specific regulation. *Labour Law and Labour Relations Programme Working Paper No. 2*. Geneva: ILO.

control over their work and, in particular, limiting their possibility for changing employers.³⁰ As has been argued elsewhere, the power to quit can be particularly important for people working in low waged insecure work (Smith 2006), and it is particularly contested for migrants who may be tied to particular employers because of a work permit/sponsorship relation. The freedom to change employers was the subject of a long running campaign by Kalayaan and was won in 1998, though it continues to be a contentious policy issue.³¹ Under current UK immigration law, MDWs are dependent on their employers to maintain their immigration status in the UK through the renewal of their visa. In order to obtain a successful renewal, MDWs must show evidence of their employment, usually through payslips and a letter or contract from their employer confirming their employment. After working in the UK for five years, MDWs may apply for ILR but in order to do so, they must have remained in full time employment in a private household (although they are allowed to change employers), show evidence of employment, and provide proof of payment of tax and national insurance contributions. Such documentation is an integral component of the immigration rules surrounding the domestic worker's visa, and renders all migrant domestic workers dependent on their employer for matters such as proof of employment. Several interviews conducted with migrants performing elder care work revealed that employers use this dependency as a means to exploit workers by paying them lower wages, refusing to give them time off, refusing to pay their tax and national insurance contributions, and taking advantage of their lack of familiarity with their employment rights. One such carer indicated that her employer was well aware of this dependency saying that,

they [employers] get you in their hands and you are working there...they know that you don't want to change something, and you need that piece of letter. That's all that matters. So they can twist you around the finger. I have to apply for my visa. I need that letter (C7).

Similarly, when another MCW tried to negotiate a night off with her employer, he threatened that he would not renew her visa: "He would tell me "take it or leave it, it's up to you. I will not renew you, if you want to remain [working here] stay like this" (C3).

Some employers also took advantage of MDW's lack of knowledge about their employment rights. One interviewee described how her employer had said to her "you can't leave us because we brought you into this country so you can't work for anybody else apart from us". After being made aware of her employment rights at Kalayaan, the MDW realised that she was free to change jobs under the current immigration rules. Similarly, another interviewee explained that her employer had tried to make her sign a contract guaranteeing that she would work for her employer for four years. While these examples are not intended to convey that employers are universally bad and exploitative, they do however demonstrate some of the issues which MDWs experience as a result of their dependency on employers.

Thus the ambivalent attitude of migrant care workers to written contracts needs to be understood within the context of their understandable sensitivity to constraints on their labour mobility which are already greater than those of non-migrants.

³⁰ See Anderson et al. 2007.

³¹ Kalayaan's campaign to maintain the domestic worker visa and the associated protections it carries for migrant domestic workers had an important success in June 2008 when the government reversed its proposals to remove many of the protections from migrant domestic workers in the UK. However, ongoing campaigning work is being conducted by Kalayaan, not least because protections for this particularly vulnerable group of workers are not guaranteed beyond the first two years' operation of the Points Based System at which point they may be reviewed.

Social relations

It is clear from the above discussion that the formal employment relationship is closely bound to the social relationship for MCWs. Although migrant care workers never indicated that building good relations with the care user was part of their contract, in many instances this was implicit within the job description. Building a good relationship with a care user may be both priceless and worthless at the same time. A care worker who helps develop relations of mutual affection does not –in so doing –earn more. While contractualised relations are generally felt to be more professionalised and less emotional as compared to more familial type relations, in practice the relation between formal employment status and social relations is more complex. The following case studies provide examples of this range. In the first case study, the hours and tasks were agreed between the two parties despite there being no written contract. In contrast, the second case study provides an example of what can occur when no agreement on hours and tasks has been made and, as a consequence, the carer is expected to conduct any tasks that the employer requests. Finally, the third case study provides an example of a more flexible relationship where, although the care worker is expected to perform many tasks which fall beyond the job description of a care worker, the relationship between her and the care user is more familial in nature:

Case study 1: C31

I work six hours from 8 till 2 and then it's my break. After, I go back. I just eat, we just eat dinner, that's it. I go back around 5.30 we play cards. Afterwards, we chat. Then I prepare our food. From 6.30 we have dinner. I rest from 7 to 7 and I have one a half days off [...] the first thing to do is to make her have breakfast. Breakfast and then tidy up in the kitchen. And then when she's done, I will also clean her, what is it? Her room. Then we will exercise after that [...] She eats the same thing, all microwaved. I don't cook, just once in a while when her son is there... I shop on Thursday and Friday for her.

Case study 2: C10

When I came the first year, oh my God, she wants everything to be done, like all her night dress, she want to be shortened. Because there's all these things she wanted me to tend to, even the old curtains [...] If somebody is coming, [she asks] "Can we extend time? Can you do my daily...?" Anything that - like accidental happens or...she will ask you. Because you are there, what are you there for? And she knows. So you can't be like the chef, you can't say "No, I'm not going to do it".

Case study 3: C16

Like when I am tired as well, she also understands. Especially when there are visitors and I've been cooking, she would say "Go ahead, you rest, I'm now okay, you can go. You rest because I know you are tired" ...if I can't do it for example I don't have time, I would say, "Sorry maybe the next day or tomorrow I will make that bit. Just a moment because I have lots of work, I am cooking this because we have lots of...we have visitors today so I'll work on that tomorrow, is that all right?" She [employer] says "Okay." 'They understand somehow. It also depends on you [...] Sometimes when I go back home, I have so much luggage - she gives me so much stuff. She buys me - I left the watch- but she

gave me a Rolex. Sometimes during Ramadan, their Christmas, she gives me at least 1 ring or earrings. Yes, they buy me - that's 22 Karat.

While there are differences in the three case studies, what they have in common is that it is the care user as the employer who determines the nature of the relationship. Indeed, there is an imbalance of power that means that employers can oscillate between one end of the spectrum and the other. The following example describes such a situation where the employer alternates between asking the care worker whether she can work extra hours or complete extra tasks beyond the job description yet on other occasions describes their relationship as strictly professional: "It's not my job to do that [look after a child] but I do it. But then they do things to you like "you're my worker." And then when they are talking, "Oh she's family, blah blah blah. Rubbish" (C7).

Many of the migrant care workers interviewed described situations where additional work was requested beyond the remit of the job. One of the interviewees summed the situation up as follows: "If you're close with the care user, they can always slip in extra work like "Oh can you do this? Can you clean this one?" Things like that. I think that's where the real abuse can slip in.³²"

These examples beg the question of reciprocity and whether this slippage is a benefit enjoyed by both parties. If the relationship between the two parties is flexible on both sides, and if such requests for additional work are also combined with comparable requests from the carer such as for additional hours off or holiday leave, then the above may actually present examples of good employment relationships. However, the majority of the interviews conducted indicate that this was not the case.³³

In addition to the question of reciprocity, it is also important to examine what kind of relationship is desired by both parties. Such preferences are likely to depend on individual personalities and priorities and may vary over time. Employers and migrant care workers are arguably both pulled towards a familial relationship because of a shared sense of vulnerability, albeit for different reasons. Where the older person is also the employer, they may feel vulnerable because of their dependence on the care worker's assistance. They may also feel socially isolated and hence may prefer a more familial type of relationship. This desire may also help to assuage their sense of impropriety at allowing a worker, particularly a foreign worker, to have access to the inner workings of their private lives. Migrant domestic workers may also prefer a familial type of relationship since this not only provides them with job security and an ability to send regular remittances home, but also it enables them to form personal relationships in the absence of their own friends and family. This may be helpful in partly offsetting the social and cultural isolation which many domestic workers face, even where migrant social networks are present.³⁴ Yet, despite the migrant care workers' desire for a familial relationship, they are likely to be acutely aware of their dependency on their employer for maintaining their immigration status. As will be demonstrated, this dependency is exploited by some employers. So, from the very beginning, even if there is a mutual desire for a familial type of relationship, the relationship is rarely based on equal terms. Employers can therefore bend the contract to serve their own needs and the worker can be forced into maintaining a familial relationship because of the fear of reprisal which could affect their immigration status. Such a situation can be contrasted with employment relationships with British workers, where the nature of the

³² Interview with domiciliary care worker, C31.

³³ It should be pointed out though that care users were not interviewed during the course of this research project and thus the testimonies presented here are one-sided.

³⁴ This is usually related to the fact that the domestic worker is likely to have only one day off during which they can access this migrant social network and may otherwise have little social interaction.

relationship is likely to be more contractual (see Anderson 2007).

It was evident that many care workers desired a nurturing relationship with their care user. Indeed, the majority of them used familial terms and references to describe the care user such as 'mother' or made comparative references to the care user as being 'like my parent'. Interestingly, some care workers also indicated that such a highly personalised, familial relationship was what 'devoted' care workers ought to establish with the care user and took pride in this: "...of course if you're really devoted, you would make yourself – you would consider her as your mother already. I do everything for her. I never raise my voice to her, never hurt her" (C14).

Within the sample, there were three significant exceptions, each of which highlighted the importance of separating care work from one's personal life, and which implied that care workers sought a more formal, contractual relationship. Interestingly, all three of these cases had at least four years' experience in care work, and two of them were working for a home care agency. Although these cases were not exceptional in terms of experience in care work, it seems likely that the experience of agency home care work may have impacted on their desire to separate their professional and private lives. Indeed, two of the care workers commented that the agency provided them with a list of tasks that they were expected to complete, and monitored this from time to time. The third care worker was male, and had worked in a variety of care settings and seemed to work with many different clients on a weekly basis. Thus, as indicated above, agencies with good practices can act as an intermediary between care user and care worker to formalise the contractual aspects of the employment relationships, thereby preventing the aforementioned slippages in employment relationships. In addition, the desire to maintain a strictly professional relationship with the care user may also result from working in more than one household, as agency work often necessitates, or, as in the case of the male care worker, is the result of working with several clients in different care settings. However, the desire for a more formal relationship with the care user should not be equated with the refusal to provide the personalised care and emotional support that is an integral part of care work. Rather, it reflects the need to maintain personal boundaries. As one male carer stated:

I always try to maintain a professional relationship with clients, at the same time you do have a good relationship most times with most of the clients because what usually happens is most clients have emotional needs and all, so for a client, they have confidence in you and talk to you about different things and different aspects of life (C41).

In addition to establishing highly personalised relationships with the care user, some of the respondents also developed relationships with the care user's relatives. This is arguably the result of the social isolation which many migrant care workers experience when performing live-in home care work. Such isolation can render care workers dependent on the relatives for emotional support, particularly when the care user dies. In other cases, however, respondents mentioned difficulties in dealing with the relatives of the care user, particularly when the care user had close relatives who tried to interfere with the care being provided by the care worker. Such situations were sometimes further complicated when the carer had developed a particularly strong relationship with the care user, and resentment and rivalry developed between the relatives and the care worker. These cases highlight the need for pre-agreed care plans to be implemented in order to minimise arguments over the details of the care being provided; such plans were noticeably absent in the majority of cases.

Skilled nature of domiciliary care work

Social care work has traditionally been seen as 'low-skilled' because of the intrinsic undervaluing of women's unpaid care work.³⁵ Yet, the inter-personal skills displayed by the respondents demonstrate quite the opposite. In particular, care workers show considerable tolerance towards their care users even in the face of verbal and occasionally physically abuse:

She gets angry easily and she wants that when she calls for you, you heed right away. At times when it takes you long to respond to her, she would get mad and shout. But I try my best that she remains calm (C16).

In addition, despite the low level of formalised training which many of the care workers had received in care work, many of them displayed significant people handling skills, which enabled the worker to manage the care user effectively, particularly when the latter was facing emotional or physical distress:

When they get dirty- elders, they get very upset. They don't like to tell you what happened. No matter how much she loves me, she gets very aggressive. I talk to her gently, that's what I do, understanding, everything because she [the care user] never likes to be like that (C8).

The development of such skills appeared to correlate quite strongly with the amount of time the worker spent caring for the individual, with several care workers commenting how it was a matter of learning when and what to do in certain situations. One such example is shown below, and it indicates the importance of continuity in the provision of quality health and social care³⁶:

Because when she work – when she talk with me, I realise what she – her habit, what's she like. I realised, work her in one time, second time I did. If she's not happy, I think, next time, oh she's not happy but this time, I want to do another way. So, I find out her attitude then I realised everything (C30).

Personalisation of care

The underlying argument for personalisation of care is that it transforms care users from passive care users into agents with choice and control over the care that they receive. It also has the potential to be cost efficient as individuals can sometimes purchase their care or support at a reduced cost as sometimes the care is of a more informal nature (e.g. a neighbour or friend). There are also reduced overheads, particularly local authority overheads which include the cost of social workers, commissioners and other support services. Personalisation includes within its remit direct payments, individual budgets, personal budgets, user-led services, self-directed support and the In-Control pilots, and the government has announced its intentions to have 30 percent of care personalised by 2011.³⁷

Although it has been a successful exercise thus far for disabled service users, several concerns have been raised by industry stakeholders and experts with regards to the personalisation of elder care.³⁸ In particular, there is concern over the fact that little

³⁵ Lewis 2006.

³⁶ Cangiano et al. 2009.

³⁷ Interview with Gill Vickers, June 2009.

³⁸ See Ungerson 2006 for a discussion on the impact of direct care payments

attention has been given to the impact of personalisation of care on employment relationships between care workers and care users. Ungerson (2004) has pointed out that personalisation may foster the development of an informal market for care in which migrant workers, and particularly undocumented migrants, may be particularly desirable. Meanwhile, trades unions have expressed concern that the introduction of direct payments and personalised budgets in the context of local authority funding shortages could force service users "to exploit vulnerable workers".³⁹ Indeed, the types of contractual problems which respondents reported during the interviews, such as; low wages, refusal to pay national insurance and tax contributions and excessive working hours demonstrate that these are timely concerns and, as such, are only likely to increase in the context of the ongoing personalisation of care. The examples below demonstrate some of the issues that were raised during the interviews which relate specifically to personalisation of care. The first example indicates that some care users have greater expectations of the care worker when they are paying directly for their own care:

they want to make you work for every penny they pay you. That's how you get into a situation where you have to clean all the windows, the silver, the carpets, just for the sake of doing something rather than for you to sit down and have a bit of a break...In that case the agencies they do help you in that situation because they are kind of in control (C36).

In addition, some care users have underestimated their care needs during the self-assessment⁴⁰ and may therefore look to the care worker to provide those additional hours without payment.

If an individual uses their personal or individual budget to employ a care worker as their personal assistant to provide care, the individual is responsible for paying tax and national insurance on behalf of the care worker. Although in some cases, this may be arranged by relatives, in others it may fall directly on the individual care user who may not understand their responsibilities as an employer (including important areas such as health and safety) with a resultant lack of protection for the care worker:

Like nowadays to get my money, I have to beg on him. If he doesn't want to go to get cash for me, that means...it's very hard. [I tell his daughter] It's not begging. It's my pay. He didn't pay me for last week. That's the money I'm asking for (C42).

Individuals who have a personal budget can continue to purchase traditional domiciliary care through a care agency but many prefer to employ one or two personal assistants who are self employed as this provides both continuity and flexibility of support. However, this can lead to the formation of quasi 'employment agencies' registering a number of self employed personal assistants on their books and these agencies as they are not officially providing personal care services directly, cannot be accredited by the local council. Not only is this likely to expose migrant care workers to further vulnerabilities when working directly for such care users, but also they may get drawn into these 'unofficial' agencies which are already cropping up in certain parts of the country.⁴¹ As these 'unofficial' agencies are not subject to regulation they could potentially exploit the vulnerable position of migrant care workers.

39 Cangiano et al. 2009 p.30

40 Interview with Gill Vickers, June 2009.

41 Ibid.

Conclusion

This section has highlighted the complex contractual and social relations elements of the employment relationship between migrant care workers and their employers. Although agencies can theoretically provide migrant care workers with a highly contractualised relationship, in practice this is very much dependent on the individual practices of the agency, and these can vary significantly. Further research into the implications of being self employed or a worker for an agency would help to delineate more clearly between the problems faced by individual groups of agency workers.

In cases where care workers were directly employed by the care user or their family, there was a noticeable lack of formalised contracts. Even in cases where migrant care workers did have written contracts, there tended to be considerable discrepancies between the tasks and working hours in the contract, and those required in reality. In addition, it was found that some employers appeared to use the worker's dependency on them for maintaining their immigration status as a means to exploit them by paying them lower wages, refusing to give them time off or refusing to pay their tax and national insurance contributions. Such inequalities in employment relationships underline the lack of regulation within the domiciliary care sector as well as help to explain migrant care workers' somewhat ambivalent approach to formal contracts.

Meanwhile, the social relations element of the employment relationship complicated the picture further. Although migrant care workers tended to favour a more familial type of relationship with the care user (and in some cases with their relatives), the imbalance in power relations between the two parties resulted in employers frequently oscillating between a more contractualised relationship, and one that was more familial. Such imbalances in the relationship underline the need for more emphasis on reciprocity within the employment relationship as well as greater consideration for what kind of relationship is desired by both parties.

Finally, the issues raised with regards to both the social and contractual elements of the employment relationship are likely to become more pronounced in the context of ongoing personalisation of care, and could, as has been shown, lead to further insecurity for migrant care workers as well as for care users.

Having examined how migrant care workers negotiate their employment and social relationships with their care users and families, the next section focuses on the role of race and racism in their employment relations.

Section Three: How does race and racism impact on the employment of migrant care workers?

Introduction

There has been some exploration of the racialised and gendered nature of the demand for domestic workers.⁴² Previous research has demonstrated that migrant care workers experience racial discrimination from the care user, their relatives as well as their co-workers and supervisors in a variety of care settings.⁴³ In private households, racial discrimination may be particularly difficult to deal with because the isolating nature of domiciliary care work means that there is often no one to whom the care worker can report experiences of discrimination, such as a care home manager or a co-worker. Drawing on in-depth interviews with domiciliary care workers and telephone interviews with recruitment agencies, this section will examine the ways in which race and racism impact migrant care workers' experiences of work. It will explore the two main areas in which migrant care workers performing domiciliary care work experience discrimination: at the point of entry into care work and within the job itself. It will also touch upon care workers' perceptions of their employers.

Discrimination at the point of entry into care work

Both care users and agencies indicated preferences for employing particular nationalities and/or races. In some cases, racism was explicit and crude, with negative attributes directly associated with skin colour. One agency interviewee, in particular, stated that darker skinned workers tended to be less honest than white workers, and would be more likely to steal money from the care user or ring up hefty telephone bills at the care user's home: "I'm afraid this is the mentality of the darker skin, they have less compunction about being honest, and it's always the darker skin" (Agency interviewee).

More generally, however, agencies concealed racist remarks through referring to 'national characteristics'. These were not necessarily negative, and positive 'national characteristics' were given as reasons for employing certain nationalities. The correlate, that there are also negative national characteristics (meaning that there can equally be reasons for *not* employing certain nationalities) was sometimes explicit:

many older people prefer the softer side of the Filipino. There is a big difference, you get a lot of lovely Indian women but they can be a bit harsh. Even Indians [employers] prefer Filipinos because they want someone more educated in their house, someone that has good English.

It could also be implicit:

We prefer British. They are very good. They [the care users] feel at home with their own people. They feel safe. We do have some Filipinos as well who are properly trained nurses. They are very clean as well. They look good (Agency interviewee).

Interestingly, some agencies, unlike the one quoted above, were reluctant to use British workers: "our clients don't like Europeans. They say what will they do in the house? English people would rather take unemployment benefit than do care work."

42 See Anderson 2007, Cox and Watt 2002, Rubery, Smith and Fagan 1999.

43 See Cangiano et al. 2009, Duffy 2005, McGregor 2007.

While of course 'British', 'Europeans' and 'English' people can be black, the context within which these kinds of comments were made strongly associates them with whiteness. Negative stereotyping of British/white workers, and positive stereotyping of certain non-British/BME⁴⁴ nationalities can be difficult to challenge, as racism is generally held to be a matter of negative rather than positive stereotypes and to work in favour of white workers. When the comparison is implicit rather than explicit, and/or if it is accompanied by negative comments about British people, it may not be conceptualised as 'racist'. Similarly, allusions to particular nationalities as being 'clean' also carry implicit, highly racialised stereotypes – if some nationalities are clean then others are 'dirty' – that are nevertheless not overt. Moreover, perhaps unsurprisingly, some migrants respond to the apparent acknowledgement of such stereotypes. This can have a market value, resulting in higher wages (see for example, the passages below):

They [employers] prefer us [Filipinos] in every way. From the nursing I think, even in the hotel when the applicant is Filipino, they are with a smile because they said that the Filipinos are not argumentative. They are good workers. They said they only argue with themselves. But with regards to work, oh they are 100 percent very good. You could rely on them...with regards to old folk and even to the children because they said that even the Filipinos, even when they are young girls, they know how to look after babies. They know how to look after children. And they are very patient (C35).

That's why she likes Filipinas, we are clean, neat and hard working. She doesn't want other nationalities. Others wanted to work for her but of other nationalities, she doesn't want them. Mrs S is choosy. She liked me because I also do her nails, massage her. I also fix her hair after bathing. We [Filipinos] are known to be affectionate and attentive (C34).

It is interesting to note that being regarded as belonging to a 'hardworking' nationality is presented as flattering by these two Filipino nationals. This contrasts with some interviewees from Zimbabwe and India, respectively who were also regarded as 'hardworking', but who experienced this as being well-suited for hard physical tasks and harsh conditions:

They always expect me to lift them. They are always saying because I am from Africa I am strong. Because they know the people from Africa carry buckets of water on their hand and walking and awful things, so that is one of the problems I have, they always think I am up for anything...which is hard sometimes (C36).

They [employers] only know Indian are never....Indians will close eyes and work, work harder. They wanted Indians to work here' (C11).

Sometimes, the reasons given for employing or not employing people were related to issues to do with their 'culture'. The term was used in practice to refer to a wide range of characteristics, some of which are more easily attributable to country of origin than others, and some of which are more relevant than others. For example, language skills can be extremely important in the provision of quality care, and nationals of certain countries may, for example, because of reasons related to colonial history, be more likely to speak English than nationals of other countries. 'Cultural difference' was also used to highlight negative behavior and attributes of certain groups. This is illustrated in the following passage: "the different way that they live: if they [Eastern Europeans] see food they want to eat it there and then and if it's there, they just help themselves," (agency

44 Black/Minority Ethnic

interviewee).

Racism helps channel certain groups into 'low' status work by seeing them as particularly suitable for it. Some Asian and African care workers indicated that some recruitment agencies associated them with certain characteristics, and in some instances this does seem to be the case. For example, one agency interviewee commented that African and Asian migrants were employed in private households because "they do everything"⁴⁵, while another stated "when the black girls are good, they're good, they don't mind what they have to do." Meanwhile, another agency interviewee singled out South African and Zimbabwean migrant care workers stating that they "work hard". In considering racism within the sector it is also important to bear in mind the low status which is attached to care of the elderly in the UK. In a vicious circle it often seems that one reason migrants can find work in the sector is because of its low status, and conversely one reason that migrants are not respected is because they work in low status jobs.

Discrimination experienced within domiciliary care work

The kinds of stereotypical 'national characteristics' mentioned above as facilitating entry into eldercare in general, and as segmenting the labour market with different groups considered more or less desirable, also affects working conditions. Some care workers felt that the idea that some groups are 'hard working' or 'strong' meant that they experienced differential treatment by the care user in terms of both the amount of work they were expected to complete and the tasks they were asked to perform. A few of the care workers interviewed also recalled being asked to perform degrading tasks. An Indian carer described how the care user expected her to perform enemas on his constipated dog: "Oh and I look after their dog. Their dog get constipated. Oh, I got to put my hand, put a Vaseline, oh my God..." (C7).

Sometimes where two or more migrant care workers of different nationalities worked together, interviewees claimed discrimination in terms of work allocation. In particular, Asians and Africans who were placed with British and white care workers alleged differential treatment. During a focus group conducted with migrant care workers, an Indian care worker revealed the differential treatment she experienced vis-à-vis the allocation of tasks when she worked simultaneously with a British care worker. She described how the care user entertained guests frequently, and that she was expected to cook and serve food and drinks while the British care worker was asked simply to socialise with the guests. Another Indian interviewee commented how:

The Australian was treated very nicely, because, you can see the partiality like... she got paid properly and then from the way she was treated you can work out that there is different type of treatment for one and the other one is different. For us, she didn't care if we had eaten or not or she doesn't even give us to time...but for her [the Australian] she did (C1).

One area where it is possible to verify claims of discrimination is concerning wages. As with domestic work in general, care workers performing domiciliary care experience discrimination on the basis of their nationality and/or race in the form of differential wages. Filipinos tend to command the highest wages of all nationalities with wages ranging from £250 per week to £490 per week gross. This is linked largely to the previously mentioned 'national characteristics' associated with Filipinos. In contrast, Indians generally command lower wages (ranging from £100 per week to £350 per week gross). This is partly related

45 Recruitment agency interviewee

to the fact that some Indians are employed by Indian or British Indian employers for language and cultural reasons and who also tend to pay less.⁴⁶ During a focus group conducted with care workers, an Indian care worker commented how she was paid below the national minimum wage while a British care worker in the same household was paid close to £10 per hour. Similarly, another Indian care worker indicated that she was paid substantially less than a Portuguese care worker who was doing the same work.⁴⁷

Although the majority of African care workers who were interviewed actually worked for agencies, some of them commented on the low level of salaries which they received. A male Zimbabwean care worker commented that British care workers received higher salaries than Eastern Europeans, Africans and Asians.⁴⁸ Meanwhile, a Zimbabwean domiciliary care worker stated that she had previously received only £5.75 per hour while another employer had only paid her £60 per day, even though she was on call 24 hours a day.

Migrant care workers' perceptions of employers

Employers and care users were not alone in slipping between race and nationality. Migrant care workers made similar slippages when discussing their perceptions of their employers. Indeed, several care workers indicated a preference to work for British families stating: "I like English family because English family is better. English people, no like this bad habit" (C18). Another carer stated, "...the white skin, they will pay properly (C7).

An interview with a Community Advocate at Kalayaan revealed that this is a common occurrence with the MDWs that they see at the organisation. She explained that,

Workers often indicate a preference to work for a British family but they don't expand on what 'British' means. If you ask them what they mean by this, they don't seem to differentiate between British Indian and Indian so one assumes that when they say 'British' they actually mean 'white'.

However, she cautioned that such a preference may not be the result of having actually worked for a white British family, but rather perhaps a friend of theirs may have worked for such a family and may have been treated well. Generally, such a preference is based on an assumption that British families would treat the worker better because not many British families bring over domestic workers. For example, Filipinos who tend to command the highest wages have a preference for white, British families because they see such employment as a 'dream job' where they have higher earning potential.⁴⁹

The preferences of the worker vis-à-vis the nationality of their employer also tended to relate to their experiences with their first employer with whom they came to the UK. Poor treatment by a certain nationality would make the worker extremely hesitant to work for a family of the same nationality in the future. For example, some domestic workers were wary of working for Arabic-speaking employers as a result of poor treatment they received in the Middle East.⁵⁰

Another interesting finding related to migrant care workers' perception of the religion of their employer. In particular, it was noticed that in cases where care workers worked

46 Interview with Community Advocate, Kalayaan July 2009.

47 Indian domiciliary care worker

48 Interview with Zimbabwean care worker.

49 Interview with Community Advocate, Kalayaan July 2009.

50 Ibid.

for Jewish employers, the care worker described the employer in terms of their religion rather than their nationality. So, for example, when asked if they worked for an English family, they replied, “No, Jewish”⁵¹. A Community Advocate at Kalayaan also indicated that this reference to British Jewish families as ‘Jewish’ was common. She indicated that this may be because religion tends to be an important factor for domestic workers. She had frequently witnessed domestic workers asking each other about the religion of their employers as well as their own religion, and believes this has the capacity to bond as well as divide domestic workers.

Racism in private households: who is to blame?

As discussed in section two of the report, employment relations, both formal and informal, within this sector are extremely complex. This means that while it is clear there are racist employment and recruitment practices occurring in private households, it is not clear where responsibility lies for addressing them. As the following passages show, some of the treatment of workers by care users is extremely offensive:

Older people have tantrums with them. They treat them like- sends them away, certain black people or make them slaves. They don't want to work with them. I sometimes pair with a black person and it is – but I sense and feel that they are reluctant to work with them. They say “don't touch me”.

The migrant care worker contrasts this experience she had of working with black care workers with another experience she had when working alone with a care user:

because my accent is not very strong. So one of the persons said, “I don't think you are a foreigner. You look normal. You speak good English”. And it was a racist. Wasn't it? You look normal (C44).

In another example of an Indian migrant care worker:

From day one “I hate you. You're black. You are this. You are that. You look so horrible. I don't like you. I want you out from my apartment. You want to come and rob me.” She pinches me, slaps me (Indian home care worker).

As a Zimbabwean carer explained,

If you're black, if you're an African, some of the elderly people, you know their generation, they are racist. They can't even tell you in your face to say I don't like you. Why don't you like me? Because you're an African, you're black. I don't like you (C40).

However, the care user may themselves be vulnerable and/or suffering from dementia, which makes this kind of behavior even more difficult to deal with. This point is sometimes made by agencies, who may also claim that their practices are simply a market driven response to the racist attitudes of clients, or indeed a way to protect workers from racist abuse. Private households are exempt from the Race Relations Amendment Act in 2003, and it is legal for an employer to refuse to employ someone in their own house on the basis of their colour or nationality, although it is no longer legal to discriminate on the grounds of race, ethnic or national origin. Agencies are evidently not included within this exemption and are expected to follow non-discriminatory practices. However, in reality

51 Interview with Sri Lankan domiciliary care worker.

this line is often crossed since the race and/or ethnic or national origin is often key to the 'matching' service which domiciliary care recruitment agencies provide. For example, one agency interviewee commented that they tend to find out the preferences of the care user in advance so as to try and prevent their care workers from being put in a situation where the care user may be racially abusive: "If I ask ten times a day whether it would cause upset if I sent a coloured carer, 40-50 percent will say yes its okay. If they say yes then I won't send a black or a brown carer."

However if agency workers do report problems of racial discrimination to their agency, there is not necessarily any action taken, and in one interview for example, the worker described how she was sent back to work for the same care user.⁵²

Conclusion

The findings in this section have shown the extent to which race and racism interact with migrant care workers' experiences of work at the point of entry into employment in the care sector and also within the job itself. It is also important to recognise the highly gendered and aged segmentation of the labour market. For example, agency interviewees indicate that there is a strong preference for mature female care workers. One agency interviewee described the demand as being "always female, kind, caring, trustworthy, honest and reliable," while another agency interviewee indicated that in the last seven years she had been unable to place any male care workers: "female care users do not feel it appropriate to have a male carer doing their bathing and toileting and some male care users also feel that it's not proper." Agency interviewees tended to put the preference for a more mature female (often 30 years old and above) down to the fact that older people tended to feel more comfortable with someone who has more life experience.⁵³

The inequalities experienced in terms of pay, allocation of tasks and overall treatment within the job raise issues with regards to the regulation of domiciliary care work as well as care workers' access to employment rights. In particular, the differential treatment experienced by African and Asian migrant care workers who were employed alongside care workers of other nationalities demonstrates the extent of the uneven power relations between employer and care worker within private households. Such examples are of particular concern in the current context of ongoing personalisation of care, and indicate a potential conflict between increasing care user's choice and ensuring care workers' access to employment rights. They also highlight the need for greater support of care workers in domiciliary care settings through the local authority, and the development of a national helpline such as the one which Care and Counsel currently operates. Improved access to training opportunities would also be useful in terms of helping migrant care workers to manage situations in which they encounter racial discrimination, for example through the use of breakaway techniques.

⁵² Interview with Zimbabwean agency worker

⁵³ Interview with recruitment agency

Section Four: Recommendations

This final section of the report draws on the findings of the previous sections and makes general as well as specific recommendations which relate to the care user, the care worker and employers who may be care users, the families of care users, local authorities or agencies. We would urge all stakeholders to consider all of these recommendations. However, some may be particularly relevant to certain groups. For this reason we would draw the attention of the government to Recommendations 1 and 2, the Care Quality Commission to Recommendations 3 to 5 and social care organisations to Recommendations 5 and 6.

1. Making migrant elder care workers visible

We have used the term migrant care worker to refer to foreign-born care workers who have recently immigrated to the UK and who work in a variety of care settings. While there has been some focus on MCWs in other care settings such as care homes, considerably less attention has been paid to those working in private households. We therefore recommend that migrants' organisations, policy makers and other stakeholders recognise the important contribution that MCWs working in private households make to society through their provision of care of the elderly. This is important both in terms of increasing their visibility, which was one of the underlying aims of this project, but also in terms of harnessing their potential in the future social care workforce. If MCWs working within private households are not recognised as such, their years of experience providing care assistance may be lost since future employers in other care settings may not recognise it, as some of the interviews indicated.

In particular we recommend that a route for entry and settlement for those providing elderly care in private households be considered. Our research has found that the provision of elder care in private homes is principally *demand driven*. Migrants who provide elder care have generally not set out to do so, but they find that this is the area of work that is asked of them. We note that, unlike in other sectors, there is no organised body of employers that can lobby the government or the Migration Advisory Committee about demand for labour. There is a risk that this demand will be met by undocumented workers, with consequences for both workers and care users. Undocumented elder care provision is in nobody's interest.

We further recommend that those working in this sector be given a route to settlement in the UK (currently restricted to Tier 1 and Tier 2 entrants). The work of caring for the elderly is a vital social contribution. The work of care, rather than the immigration status on entry, should qualify migrants for citizenship. Moreover, from this research it is clear that elder care workers do not have the resources or time to undertake voluntary work. It is difficult for them to gain additional qualifications or to earn high wages. This is particularly true given the intense commitment to care users that so many of our interviewees demonstrated. We recommend that the new requirements of earned and active citizenship recognise the contribution of migrant elder care workers building a humane society that treats its elderly with dignity.

2. Personalisation of care

The fragmentation of agencies that is likely to result from personalisation means that regulation of agencies is necessary to protect both workers and care users. It is recommended that tests should be applied to agencies operating in this field as is being

done successfully under the approach laid out in the Gangmasters Licensing Act (2004). In addition, the problems highlighted in section two concerning employment relationships are likely to worsen in the context of personalisation. Recommendations to ameliorate these issues surrounding employment relations are presented in the section below on employers.

3. Employers

As we have witnessed, the market for MCWs is largely employer-driven. Employers are free to choose whom they want to provide care and what type of home care arrangement they desire. It is important to respect the dignity and choices of care users. However, the informal nature of many of the home care arrangements where written contracts and terms and conditions were generally not provided by employers can leave care workers in precarious employment situations. Indeed they are often not clear who their employer is, (or indeed if they have one at all in the case of self employment). Private employers and care workers should be supported to be clear about the different types of employment relationship that are possible. A model employment contract should be provided to employers. This should include wages (with reference to the minimum wage), hours (including clarifying when workers are expected to be available), holiday and sick pay, days off, and, importantly, provisions for when the care user dies. This last point was a significant cause of insecurity for some workers, and the death of the care user left them homeless and unemployed. MCWs should also be encouraged to ask for these written and conditions from their employers.

Key stakeholders within the care sector and social care organisations will play a vital role in making employers aware of their responsibilities. They can do so by working in conjunction with employers and educating them about the need for written terms and conditions and a model contract in order to ensure the safety of the care user and the care worker. In addition, employers need to be made aware of their responsibilities particularly with regards to the payment of tax and national insurance contributions and accident and liability insurance. These measures coupled with the aforementioned care plan will provide for the protection of both parties and are therefore likely to result in long and fruitful care arrangements. Employers who are also care users must be given support in fulfilling these responsibilities.

Interviews conducted with MCWs indicated that in some cases local council care workers provide home care assistance at certain times during the week in addition to employing other care workers. However, in other cases one sole care worker was responsible for care provision for a care user over 24 hours often for six or seven days consecutively. It is clear that this is not adequate. It means, for example, that care workers do not get adequate breaks and must sometimes leave care users unattended and vulnerable. While it may indeed be advisable for a care user to have a main care provider for the sake of consistency and continuity of care, this is not sufficient. A single care user needs multiple care workers, especially in cases where a care user requires substantial night care. Employers, particularly family members and care users, need to ensure that the main care providers are adequately supported by other care workers in order to ensure quality care and safeguard workers' rights.

4. The need for care plans

Findings related to the living and working conditions of MCWs demonstrate that care workers are often unaware of the condition of the care user when they first start the job. Moreover, care users can have idiosyncrasies that even experienced care workers find

it difficult to know how to best respond to. In addition, a focus group conducted with MCWs recommended that more information be available to the care worker on the care user's conditions. These findings underline the need for care plans for all care users within the domiciliary care sector. Care plans should include the condition of the care user, their daily schedule and medications. They should also include a risk assessment and a plan of action which the MCW can follow if necessary and should be regularly reviewed and updated. Details of the care plan must be agreed by the care worker, the relatives of the care user and, where appropriate, the care user themselves.

Care plans would help to improve the level of care received by care users as well as ensure the safety of the care user and the care worker. Interviews with care home managers demonstrated that care plans were essential to managing situations where care users became aggressive, distressed or abusive (this is particularly pertinent to dementia-related illnesses) and enabled care workers to take necessary actions without having to contact the relatives each time such a situation occurred.

It is recommended that Kalayaan advise its clients of the need for care plans for the reasons indicated above. A template of a care plan should be drawn up based on the advice of the Care Quality Commission and UK Home Care Association in conjunction with care home managers.

5. Training

As demonstrated in the section on living and working conditions, many MCWs are performing domiciliary care work without appropriate training. Yet, despite this, MCWs interviewed demonstrated competence and commitment to care work. Nevertheless, their lack of formal training is potentially dangerous to both the care user and the care worker, particularly when manual handling and administering medication is involved. We therefore recommend that funding be provided for MCWs to be able to gain access to basic training. Training should include induction training, perhaps modelled around Skills for Care's Common Induction Standards breakaway techniques and, where appropriate, a dementia course run by the Alzheimer's Society. MCWs lack of access to training is further compounded by the fact that they are unable to access government funding for NVQ level 2 until they have been working for three years in the UK.

The provision of funding for training such workers is particularly pertinent to Skills for Care's 'New Types of Worker' Programme and should be viewed in the context of harnessing the potential of this group of migrant workers who possess the skill and commitment to carry out care work. Formalising their training would also ease the transition for those who indicated a desire to work in other care settings once they had obtained ILR. Migrant rights organisations would need to discuss this access to training with their clients in the context of actively choosing to do care work as opposed to working in a variety of positions such as child care.

6. External support

MCWs performing domiciliary care work in private households are extremely isolated and, at present, have little contact with anyone outside of their migrant communities. Thus, in situations where MCWs are faced with situations beyond the realm of their knowledge or in instances of conflict with the care user over the terms of their employment, they are left particularly vulnerable. External support from the local council and social care organisations is necessary to ensure the safety of both parties and in order to sustain an acceptable level of care for older people, especially given the likelihood that there

will be an increase in such informal arrangements of care in the context of ongoing personalisation of care. In light of this, we recommend the following:

- **Helpline for home care workers:** Care and Counsel currently operates a helpline for older people, their families and unpaid carers which gives advice on issues such as funding and arranging home care. However, paid care workers are not included within the remit of this. An extension of this existing helpline or another dedicated solely to care workers should provide them with advice on access to training opportunities, problems within the job itself and contractual difficulties with their employers.
- **Social care organisations to encompass care workers within their remit:** Many of the existing social care organisations currently provide invaluable support to older people, their relatives and their unpaid carers. This support should be extended to encompass paid care workers and there should be increased coordination between carer organisations and care worker organisations.
- **Increased responsibility for agencies:** The section on employment relationships indicated that some agencies take advantage of migrant care workers' lack of knowledge over their employment rights and actively mislead them over the type of contract they will receive. Some agencies also failed to safeguard the safety and wellbeing of their workers particularly with regards to racial, verbal and physical abuse. Therefore, we recommend that agencies should indicate at the outset what type of employment contract they are offering to MCWs. In addition, policies on racism, physical abuse and complaints should be implemented by all agencies. Templates of these policies should be drawn up and national care organisations should assist in the circulation of these policies to agencies nationwide.

Conclusions

The findings of this report underline the need for greater formal recognition of migrant care workers performing domiciliary care work in private households. This needs to be coupled with the provision of funding for training as well as the implementation of external support from local councils and social care organisations. Rather than obfuscating migrant care workers' employment rights, agencies need to increase the transparency of their employment practices in order to reduce the vulnerability of MCWs. As with agencies, employers need to be made more aware of their responsibilities and should be encouraged to provide contracts with written terms and conditions and should draw up care plans which should be agreed by all parties. This will be particularly important in years to come as personalisation of care continues to be implemented throughout the country and is vital to ensuring the provision of an optimal level of home care as well as in terms of safeguarding the employment rights of the care worker.

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Appendix: Descriptive statistics

Chart One: Accommodation

Total sample size of Migrant Care Workers = 50

Note: "No answer" refers to the number of respondents out of 50 who did not give an answer when asked about this.

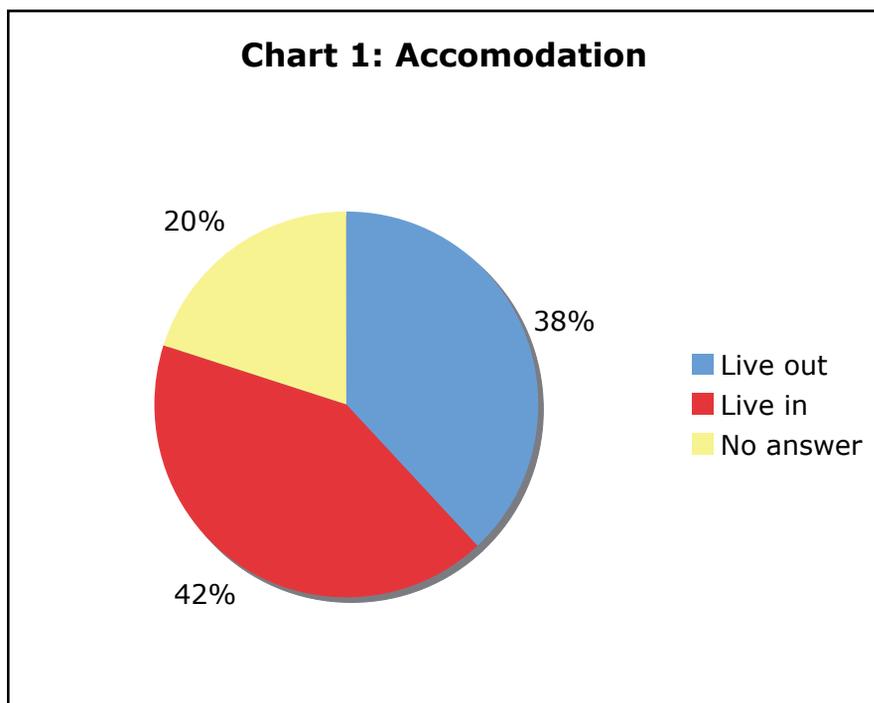


Chart Two: Country of origin

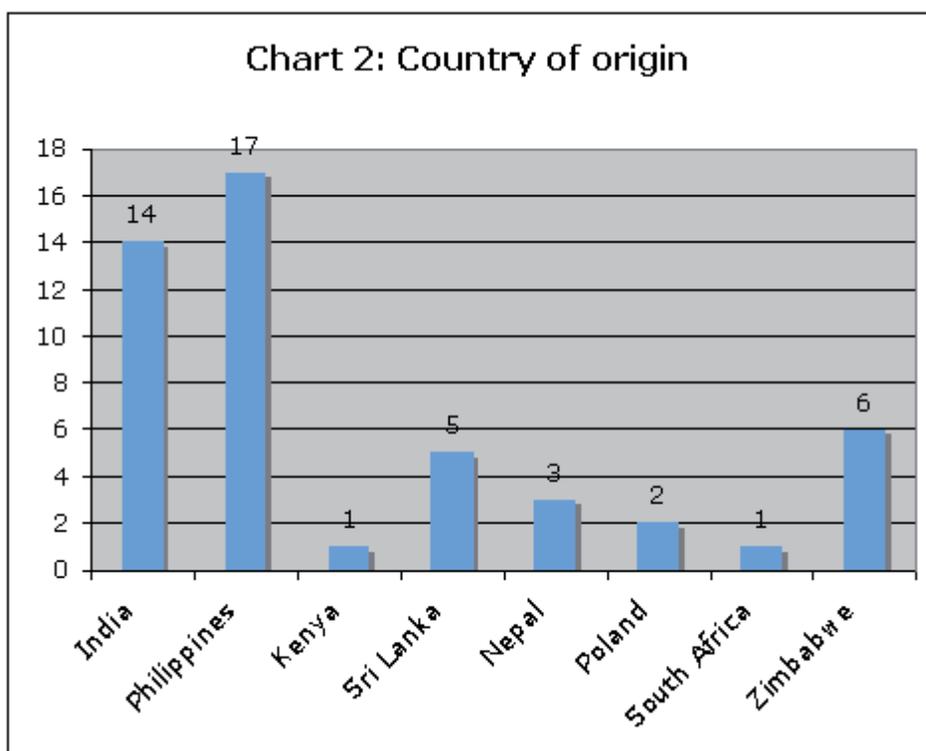


Chart Three: Gender

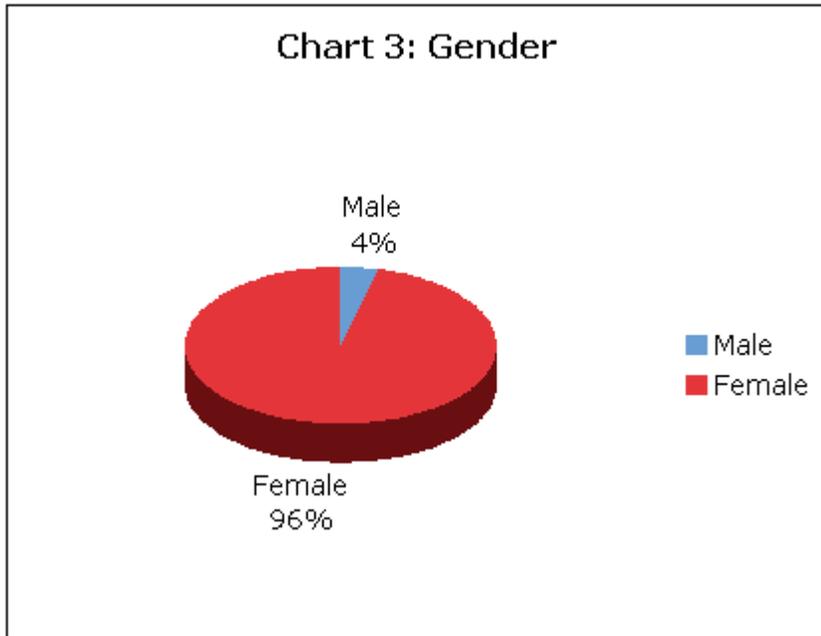


Chart Four: Number of children

Note: "No answer" refers to the percentage of respondents out of 50 who did not give an answer when asked about this.

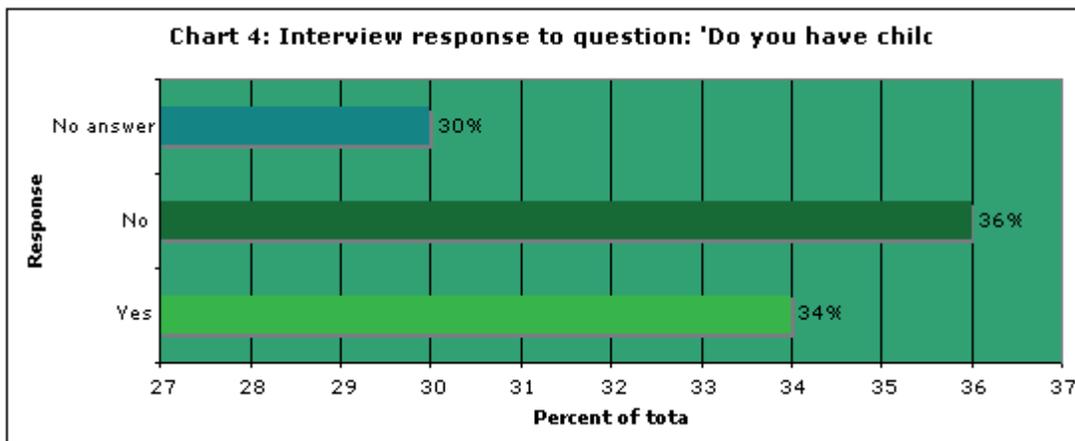
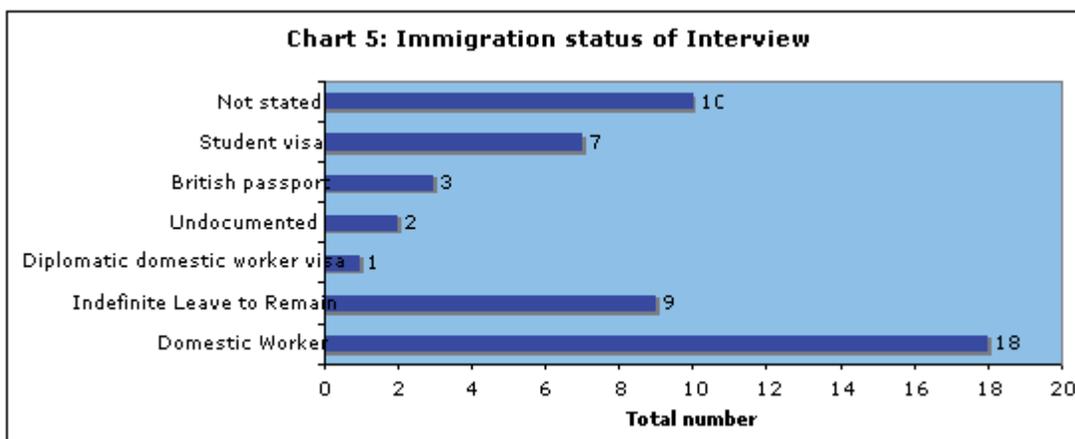


Chart Five: Immigration status



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