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Ageing, Demand for Care and the Role of Migrant Care Workers in the UK

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Abstract In recent decades, rapid population ageing has dramatically increased the need for older adult care provision in the UK. A prominent role in meeting the care needs of the older population has been played by migrant workers. The aim of this paper is to explore the characteristics of the UK social care system that shape demand for migrant labour, the conditions under which migrant care workers are employed, and older people's and migrant care workers' experiences of the quality of care. Our analysis draws on the findings of a survey of providers of social care for older people, in-depth interviews with migrant care workers, and focus groups with older people. The findings show that the underfunding of social care and interrelated workforce shortages are largely responsible for the extensive reliance on migrant workers among social care providers, and raise concerns for workforce inequalities and for the quality of care.

Keywords Migration · Social care · Older people · Labour market · Discrimination · UK

Introduction

The UK is an ageing society. The projected increase of the number of older people and their weight relative to the active population has major implications for future demand for social care. Growing demand has prompted ongoing policy debate on the reform of the social care system in the UK (HM Government 2009). While this debate continues to focus predominantly on the cost implications of demand for the sustainability of the system, workforce implications have also been highlighted (Eborall and Griffiths

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2008; Wanless 2006), but with limited attention to the contribution of migrant workers to the social care workforce (Leeson and Harper 2006).

Migrant workers (born outside the UK) comprise a growing proportion of the social care workforce in the UK (Cangiano et al. 2009). This reliance on migrant labour is evident in the provision of care for older people across western welfare states, as the articles in this special issue indicate, and in other types of care provision, including domestic work and childcare (e.g. Anderson 2000; Williams and Gavanas 2008). Demand for migrant care workers is located within the context of the 'care deficit' facing western welfare states (Yeates 2009) brought about by population ageing, women's increased participation in paid employment, changes in the availability of informal care and inadequacies in formal care services (e.g. Anderson 2000; Kofman et al. 2000; Williams 2004; Yeates 2009). Research on the role played by migrant workers in addressing this 'care deficit' has tended to focus on their employment in private households to provide childcare or domestic work (e.g. Anderson 2007), with more limited research on the employment of migrant workers in the provision of formal care services for older people through residential and nursing care homes and home care agencies (e.g. Datta et al. 2006; Doyle and Timonen 2009; McGregor 2007) and the social and institutional context in which the recruitment of migrant workers is taking place (Bettio and Plantenga 2004; Phillipson 2007; Simonazzi 2009; Smith and Mackintosh 2007).

Over the last decades, the social care sector in the UK has undergone significant restructuring. There has been a huge shift away from public providers to the contracting of private and third sector providers to deliver publicly funded care services. At the same time, growing demand for care and budgetary pressures have led to the rationing of publicly funded provision, with evidence of considerable unmet need in the provision of care to older people. These changes in the organisation and provision of social care have been accompanied by significant difficulties in the recruitment and retention of social care workers, difficulties that are related to the gendered low social status and low wages of care work, and to unfavourable employment conditions, including unsocial hours, temporariness of work and lack of career opportunities (Moriarty 2008).

This paper draws on the findings of research on the role of migrant care workers[1] to examine how these dynamics of the social care system and labour market shape demand for migrant workers among providers of social care for older people. In turn, we explore how funding constraints and workforce shortages affect the conditions under which migrant care workers are employed, and older people's and migrant care workers' experiences of the quality of care.

Data and Methods[2]

This article draws upon a range of data sources. In the following section, we refer to secondary statistical sources on demographic trends and on the funding and

[1] See Cangiano et al. (2009). Further details on the research are available at http://www.compas.ox.ac.uk/research/labourmarket/migrantcareworkers

[2] The data collection was carried out between June 2007 and June 2008. See Cangiano et al. (2009) for a full discussion of the research, including appendices on each component of the research methodology.

provision of social care. We then draw on our original analysis of the Labour Force Survey, supplemented by administrative data on migrant entry channels, to examine the trends and characteristics of the migrant workforce (born outside the UK) in adult social care. The core of our analysis is based on primary data we collected through a survey of residential homes, nursing homes and home care agencies providing care services to older people, followed up by telephone interviews with selected respondents, in-depth interviews with migrant care workers and focus groups with older people.

The Labour Force Survey (LFS) is commonly used to analyse the employment of migrant workers because of its internationally agreed concepts and definitions, including questions about nationality, country of birth and date of arrival in the UK. The collection of quarterly comparable data also provides a dynamic picture of labour force trends over time. Its limitations include the lack of information on immigration status—e.g. whether migrant respondents entered on a work permit, student visa or as an asylum seeker—and the possible under-representation of recent migrants (Walling 2006). A further problem for our analysis was that the classification by industry - Standard Industrial Classification 2003 (Office for National Statistics 2002) - does not enable one to separate out care workers providing care for older people. However, data from the National Minimum Dataset for Social Care (cross-tabulation of data collected until 31.12.2008) indicate that 71 per cent of all care workers in adult care services work with older people, so LFS estimates based on the occupational category 'care assistants and home carers' - code 6115 in the Standard Occupational Classification 2000 (Office for National Statistics 2000) - provide reasonably accurate information on the workforce in the older adult care sector.

Our survey of organisations providing care services to older people consisted of a postal survey of residential and nursing care homes, a postal survey of home care agencies, and an online survey. The postal survey of residential and nursing homes was based on a random sample of 3,800 organisations that was drawn out of 12,520 residential and nursing homes for older people listed in the Laing and Buisson database of residential care providers in the UK (2007).[3] In order to increase the coverage of the survey (in terms of workforce employed), a higher probability of extraction was attributed to medium and large organisations. The postal survey (with an adapted questionnaire) of home care agencies was based on a random sample of 500 providers of home care for older people drawn from the list of members of the UK Home Care Association (UKHCA). For both surveys, the response rate was 12 per cent, which compares favourably with the survey of employers in low-pay sectors carried out in the UK by the Low Pay Commission—the response rate for the care sector in 2008 was 9% (Low Pay Commission 2009). However, despite the national coverage, no presumption of statistical representativeness could be made because of the potential high selectivity of respondents due to the sensitive nature of the topic.[4] Our surveys

[3] Laing & Buisson is an independent company providing data and analysis on the UK health, community care and childcare sectors for research and marketing purposes. Its annually updated database of residential homes and nursing homes across the UK includes fields on the sector of the organisation (private, voluntary or local authority), region, main type of clients and size (number of beds and rooms).

[4] For example, providers employing migrant care workers under irregular terms and conditions might be reluctant to participate in the survey. This potential type of selectivity could not be controlled for.

were also made available online and advertised in the newsletters of professional associations of social care providers. Overall, 557 questionnaires were completed (480 from residential and nursing homes and 77 from home care agencies). Respondents were primarily owners or managers of private organisations (local authorities are under-represented in our sample). Over 13,800 care workers were employed by the surveyed organisations.[5] Follow-up interviews were carried out by telephone with 30 selected respondents. The survey and telephone interviews examined providers' reasons for and experiences of employing migrant care workers.

In-depth, face-to-face interviews were carried out with 56 migrant care workers employed by residential and nursing homes, home care agencies, employment agencies supplying temporary care workers, or directly by older people or older people's families (one respondent was a local authority employee). Interviewees were accessed through residential and nursing homes and through home care agencies (some of these providers subsequently participated in the above survey), through migrant community organisations, trade unions, and by snowballing through interviewees. Migrant care workers interviewed in our research were mostly women whose country of origin included Zimbabwe, the Philippines and Central and Eastern European countries. They were all foreign nationals and the vast majority had entered the UK between 1998 and 2007, while more than half had entered between 2003 and 2007. They had a variety of immigration statuses on entry to the UK and at the time of interview (including EU nationals, asylum seekers and refugees, work permits for senior care workers, domestic worker visas, student visas and tourist visas). Five of the respondents were at the time of interview, or had previously been, employed in care work without permission to work in the UK. Most respondents were working as care assistants or senior care workers in residential and nursing homes, or as home care workers. Respondents were working in England (in London, the South East, South West, Yorkshire and The Humber, and North West). The interviews explored these care workers' reasons for and experiences of working in social care for older people in the UK.

Five focus groups were carried out with a total of 30 older people, comprising current users of care provision (two focus groups with residents of residential care homes and two with users of home care services) and prospective care users (one focus group with members of community groups for older people). Participants were White British in four focus groups and British Asian in one focus group and were mostly women. While some care users were receiving publicly subsidised provision, others were self-funding their care. The focus groups with current users explored participants' experiences of care provision and their relationships with migrant care workers.

[5] The employers surveyed were asked to identify their migrant workforce according to country of birth to allow for data comparisons between the UK and other countries participating in the research (see Cangiano et al. 2009). Employers are able to identify migrant workers according to passport and visa checks for those who are non-UK citizens. They may, however, underestimate numbers of foreign-born workers among their staff who are UK citizens.

Ageing and Demand for Social Care in the UK

In the second half of the twentieth century demographic ageing reached unprecedented levels in the UK as well as in other industrialised economies. This trend is expected to continue for the foreseeable future and represents a key driver of the future growth in demand for care services. In particular, the 'older old'– those aged 80 years and over, i.e. the group with the greatest care needs—are the fastest growing component of the UK population: according to the official mid-year population estimates[6] and projections, the population aged 80 and over increased by over 70 per cent between 1981 and 2006 and is projected to double between 2006 and 2031 (from 2.7 million to 5.4 million), making up just under 8 per cent of the UK population at the end of the projection period (Government Actuaries Department 2007). This will raise the need for long-term care services well above the current levels of provision (Wittenberg et al. 2004, 2008).

Family members are the main providers of care to older people. Estimates suggest that there are around two million older people (aged 65 years and over) in the UK receiving informal care from relatives and/or friends providing unpaid help with everyday tasks (Malley et al. 2005). The availability of informal care will remain a key factor influencing future demand for formal services. According to a recent study, in England demand for informal care for older people is projected to exceed supply from their adult children by 2017 (Pickard 2008), potentially mitigated to some extent by care provided increasingly by spouses (Pickard et al. 2007).

The former Commission for Social Care Inspection (CSCI), now replaced by the Care Quality Commission (the regulator of health and social care in England), estimated that in 2006 just under 1.1 million older people used social care services in England (out of 2,450,000 older people with care needs) (CSCI 2008). Of these, 317,000 (13 per cent of those with care needs) were receiving institutional care in residential or nursing homes or long-stay hospitals, and 751,000 (31 per cent of those in need of care) received home based care (CSCI 2008). There is evidence of considerable unmet need in the provision of formal social care services to older people. CSCI's estimates suggest that, even taking into account the support of informal carers, about 450,000 older people (most of them with moderate and lower care needs) have some shortfall in their care provision in England (CSCI 2008). The inability of the social care system to meet existing demand for provision, therefore, raises significant concerns when considering rising demand in the future and its implications for public expenditure.

The question of who pays for care—the state (funded by taxation), the individual and/or the family—and the 'balance of responsibility' between these groups, continues to be central to policy debate regarding the future of care for older people (HM Government 2009). Access to publicly funded social care is means tested as well as needs tested in England, Wales and Northern Ireland (but not in Scotland, where the personal care element of care provision is free).[7] In 2007/8, gross current

[6] Mid-year population estimates were accessed at www.nomisweb.co.uk.

[7] In the case of institutional care, the financial criteria for assessing eligibility for means-tested support are determined by national rules (except for Scotland), while in the case of home care services, local authorities have determined their own criteria. This has led to geographical inequalities in access to publicly funded provision (Howse 2007).

public expenditure for care and support of older people in England was estimated to be £8.8 billion (CSCI 2009).[8] Data on private expenditure for social care is limited. CSCI estimated that in 2006 total private expenditure for older adult services—including top-ups and charges paid by those receiving services partly funded by local authorities—was about the same as the level of public expenditure. However, the proportion of privately funded services was significantly higher in residential care than in home care—57 per cent and 38 per cent respectively (CSCI 2008: 116)—mainly because the so called 'hotel costs' (costs for accommodation and meals) are usually not covered by public funding (Howse 2007).

Budgetary pressures have led to the rationing of publicly funded social care, particularly of home care services, and local authorities are increasingly directing their cash-limited budgets towards older people with higher levels of dependency. It has become much harder for older people with lower levels of dependency to secure publicly funded home care (Means et al. 2002). CSCI data show that local authority rationing of care for people whose needs are deemed 'substantial' has risen significantly in recent years. The tightening of eligibility criteria by local authorities (responsible for assessing eligibility for publicly subsidised social care), due to budgetary constraints, has resulted in a decline in the number of older people receiving support through formal provision, leaving those who do not qualify for publicly subsidised services and cannot afford to fund their care themselves with only informal support (CSCI 2008).

As regards who provides social care services, there has been a huge shift (particularly marked in England) away from local authority providers to the private and third sectors. The independent sector (i.e. private and third sector organisations) now provides services to around two-thirds of all households receiving publicly subsidised home care (Wanless 2006). According to the Laing and Buisson dataset of care institutions (2007), 78 per cent of places in residential and nursing homes having older people as their primary clients were in the private sector, 14 per cent in the third sector and only 8 per cent under the direct management of local authorities. Most providers of care for older people in the independent sector are micro businesses (i.e. with ten or fewer employees). A higher share of private nursing care homes than private residential homes without nursing facilities are operated by large companies (Eborall and Griffiths 2008).[9] Although local authorities do retain some residual capacity for service provision, their main responsibility now is to facilitate the distribution of public funds by purchasing services from the private and third sectors and to assess the eligibility of older people for publicly funded provision.

The reliance of private providers on public funding means that the rationing of resources allocated to social care affects the capacity of private providers to deliver

[8] In real terms (i.e. after adjusting for the change in prices), gross expenditure for older adult care has increased by 7 per cent relative to 2003/4, but decreased by 2 per cent relative to 2006/7 (Information Centre for Health and Social Care 2009).

[9] In recent years there has been a rise in the number of large corporate providers, including multinationals (Drakeford 2006), leading to the invention of the word 'caretelization' (Scourfield 2007: 156).

care services, particularly in the home care sector.[10] Representatives of private social care providers argue strongly that the fees paid by the state do not reflect the cost of care provision (e.g. Skills for Care and Development 2009). In 2008/9 the average unit cost of 'in-house' local authority home care was £23.20 but the average cost to local authorities when contracting independent care providers was only £12.60 (UKHCA 2010: 8). As staffing costs account for the majority of the running costs of independent care providers, the rationing of public funding is likely to have a detrimental impact on wages paid to the workforce in the sector. Indeed, our results suggest that the underfunding of social care is contributing to the reliance of the sector on migrant care workers, to which we now turn.

The Social Care Labour Market and Demand for Migrant Care Workers

Employment in Social Care

In a previous report we estimated that over 640,000 care workers were employed in the provision of care for older people across the UK in 2006/07 (Cangiano et al. 2009). Data from the National Minimum Data Set for Social Care (NMDS-SC) show that the vast majority of care workers—about three quarters—are in the independent sector (employed by private or third sector organisations), the rest working either for local authorities, the National Health Service or individuals receiving direct payments (Eborall and Griffiths 2008).

There is a marked gender imbalance in the social care workforce. According to the NMDS-SC, women constitute 88 per cent of care workers. Like its counterpart in healthcare, the workforce in social care is often described as an 'ageing workforce' (McNair and Flynn 2006), raising issues for the future staffing of the sector. However recent data and analysis suggest that this is less a concern than previously thought, as there is no clear evidence that this is in fact the case (Eborall and Griffiths 2008).

Social care is identified as one of the sectors of the UK economy where low pay is common (Low Pay Commission 2005), and direct care workers were one of the groups to benefit most from the introduction of the National Minimum Wage in 1999 (Howse 2007). The median gross hourly pay for care workers (excluding senior care workers) in adult social care services (including services for older people and other adult services) is £6.56 (Dec 2008–Feb 2009), a little above the National Minimum Wage (set at £5.73 in October 2008). However, significant differences exist across the care sector, type of services and regions of the UK, with lower wage levels in the private sector, in nursing homes and in the North of England (Skills for Care 2009).

Staffing costs make up a high proportion of the running costs of care providers. Care assistant wages account for just over half the unit costs of local authority commissioned home care services. In residential care, labour costs are estimated to

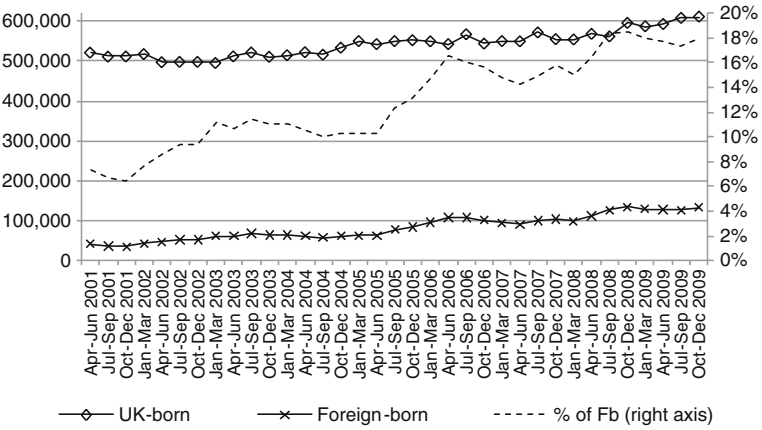
[10] Local authorities are the main purchasers of home care. According to the UK Home Care Association (UKHCA 2010), 60 per cent of independent providers rely on local authority funding for more than three-quarters of their business, with almost 15 per cent having local authorities as their only purchaser of services.

account for just over half the weekly 'fair price' for residential homes, and two-thirds for nursing homes (Wanless 2006: xxv). This makes the way in which social care is purchased and provided very price-sensitive (Forder et al. 2004; Knapp et al. 2001). Levels of pay for social care workers are limited by funding constraints in the purchasing of social care services by local authorities. The Low Pay Commission (2009) reports that the most recent Laing and Buisson survey of local authorities (2008) found that the increase in the amount paid by the majority of local authorities to those running care homes did not even meet inflation costs. The Commission's own survey of social care providers found that in two-thirds of cases, attempts by providers to renegotiate contracts following the annual increase in the National Minimum Wage were unsuccessful. The Low Pay Commission states, 'we continue to be concerned by the shortfall in funding experienced by many social care providers', and reiterates its recommendation that 'the commissioning policies of local authorities and the National Health Service should reflect the actual costs of care, including the National Minimum Wage' (Low Pay Commission 2009: 74).

Funding constraints bring to the fore concerns regarding the capacity of the sector to expand the existing social care workforce in order to meet increasing demand for care provision. The sector is already described as facing 'chronic difficulties' in the recruitment and retention of care workers (CSCI 2006: 1). In England, the vacancy rate in social care is nearly double that for all types of industrial, commercial and public employment (Eborall and Griffiths 2008). Recent trends show a sharp rise in the number of vacancies in the sector notified to Jobcentres in 2007 and 2008, mainly due to an increase in vacancies reported for care workers (CSCI 2009), with some reversal in this trend since the beginning of 2009, potentially a consequence of the economic downturn. Although there is moderate variation of vacancy rates for care workers across the UK regions, differences within regions can be very significant—with some local authorities in London reporting vacancy rates of 30 per cent (Eborall and Griffiths 2008). Turnover in care jobs is also higher than in most other occupations but significantly varies across the care sector. In England, it is relatively low in the statutory sector (9.6 per cent in 2007/8) and higher for private and third sector organisations (23.6 per cent and 15.8 per cent respectively), reflecting differences in pay and other employment conditions between the public and independent sectors (CSCI 2009).

The Migrant Social Care Workforce

Reliance of the social care sector on migrant workers has significantly increased over the last decade. LFS data for all care assistants and home carers (in older adult care and other adult care services) show that between 2001 and 2009 the proportion of migrant (foreign-born) care workers more than doubled—from about 7 per cent in 2001 to 18 per cent in 2009 (Fig. 1). The growth of the migrant share of the social care workforce occurred as a result of a rapid expansion of migrant care workers—from about 40 thousand to just under 130 thousand workers—and despite the increase in the number of UK-born workers in care jobs over the same period. Retrospective data on the year of



Source: Quarterly Labour Force Surveys.

Fig. 1 Trends in the number/proportion of UK-born and foreign-born care workers, 2001–2009

entry[11] of migrant care workers to the UK also indicate there to be growing demand for migrant care workers in recent years, suggesting that *recent* migrants (foreign-born workers who entered the UK in or after 1998) make up 12 per cent of the care workforce as a whole (Cangiano et al. 2009).

Results of our survey of organisations providing care for older people are broadly consistent with that data. Migrant care workers (foreign-born workers employed in direct care roles) made up 19 per cent of the workforce in 2008 among the residential and nursing homes and the home care agencies surveyed (and made up 28 per cent of new recruits hired in the year preceding our survey). Migrant workers accounted for an even higher proportion (35 per cent) of the nursing workforce.

Migrant care workers enter the UK on a variety of immigration statuses. After EU enlargement in 2004, A8 nationals were allowed to enter the UK and seek employment, and significant numbers took up jobs in the care sector—23,580 registering as care assistants in the period to March 2009.[12] In contrast, the 2007 EU enlargement to include Bulgaria and Romania led to highly restricted access to the UK labour market.

There is no migration entry route for non-EU migrants to work in social care except for senior care workers, formerly under the work permit system and currently through Tier 2 of the new points system (Migration Advisory Committee 2009).

[11] The breakdown by year of entry to the UK of the current stock of migrants working as care workers is a very crude measure of past inflows, excluding migrants who have left the UK or have shifted to other occupations and including those who have joined the care workforce after their migration to the UK. Retrospective information on the year of entry may lead to a significant under-estimation of less recent inflows, a larger proportion of whom may have left the UK.

[12] 'Accession Eight' (A8) nationals—EU citizens of the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia—are entitled to work in the UK provided that they register with the Worker Registration Scheme. Registrations to work in the care sector peaked in 2005 at 6,880, falling to 3,000 by 2008.

Until 2007 this channel was used by a large number of non-EU migrants (over 22,000 Senior Care Worker visas were issued between 2001 and 2006), but more restrictive criteria introduced since then significantly reduced opportunities for non-EU migrants to take up social care work in the UK via this channel. Consequently, employer demand for migrant labour is set within the context of highly restricted opportunities for the direct recruitment of care workers outside the EU.

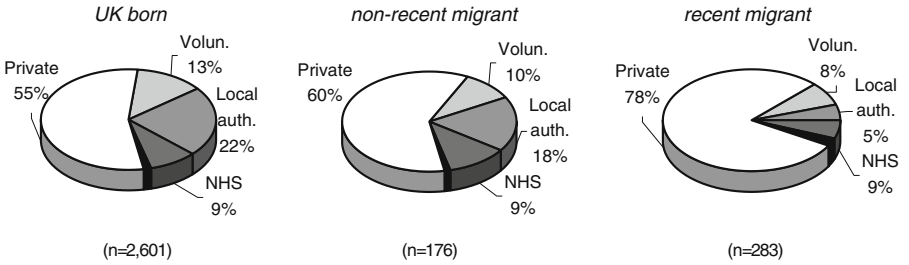
LFS data show that migrant care workers who entered the UK in the past decade came from both within and outside the EU, the most frequent countries of origin being Poland, the Philippines, Zimbabwe, India and Nigeria (Cangiano et al. 2009). Comprehensive data on the immigration status on entry of the migrant workforce is not available, but the available evidence suggests that non-EU migrant care workers entered the UK through a range of entry channels, including asylum seekers, family members, students and, to a lesser extent, working holiday makers and people on ancestral visas.[13] A key implication of this—with little recognition in policy debates—is that changes in immigration controls shaping these channels may have indirect effects on the availability of migrants to work in care for older people (Cangiano et al. 2009).

Five out of 56 migrants interviewed for this research were at the time of the interview, or had in the past been, employed without permission to work in the UK—while waiting for their asylum application to be processed or overstaying student or tourist visas. Neither our sample nor other data enable us to estimate the extent of irregular employment in the care sector. However, other qualitative studies have also identified the presence of irregular labour practices in the employment of migrant care workers, pointing to the high vulnerability of these workers—the worst situations including cases of complete lack of social protection, exploitative working hours, and human trafficking (Anderson and Rogaly 2005; Gordolan and Lalani 2009; McGregor 2007).

LFS data show that the distribution of migrant care workers across the UK is very uneven, with a high concentration in the South of England. In fact, London and the South East are by far the main regions of work, where about half of the migrant workforce is located. In London, about 60 per cent of all care workers are born abroad.

The migrant workforce is not evenly distributed across the sector. As most social care providers in the UK are private sector providers, the private sector is the main employer of both UK-born and foreign-born care workers (Fig. 2). However, migrant workers who are recent arrivals to the UK are far more strongly concentrated in the private sector than the UK-born and the long-established migrant workforce (foreign-born workers who entered the UK before 1998): according to LFS data, 79 per cent of recent migrant workers are employed by a private organisation, while this is the case for just over half of UK-born workers. There is very low representation of recent migrant care workers within local authorities (only 5 per cent compared to 23 per cent of UK-born care workers).

[13] In a previous report we tentatively estimated the breakdown by current immigration status of the migrant care workforce, showing that a high proportion—about 40 per cent—of foreign-born care workers are British nationals or permanent UK residents (Cangiano et al. 2009).



Note: recent migrants are those who entered the UK in or after 1998

Source: Authors' elaboration on a pooled sample of the Labour Force Survey (Cangiano et al. 2009).

Fig. 2 Distribution of care workers by sector, UK-born and foreign-born by period of entry, 2007/8

The over-representation of recent migrants in the private sector is reflected in their lower wages. The distribution across the wage spectrum of migrant and UK-born care workers (Labour Force Survey data) demonstrates that recent migrant care workers are over-represented amongst the lowest paid: 42 per cent of them earn less than £6 an hour (before taxes), while this is the case for 31 per cent of UK-born care workers (Cangiano et al. 2009). The higher proportion of the long-established migrant workforce employed by local authorities (18 per cent) seems to suggest that migrant carers who work in the UK for long periods experience some 'upward' labour mobility i.e. they reach the more attractive jobs in the public sector. Local authorities are also more likely to employ migrants in professional posts (e.g. as social workers) (Moriarty 2008). Essentially, this evidence shows that the workforce employed by local authorities occupies a privileged niche of the social care labour market, in contrast with the majority of care workers in the private sector, where lower levels of pay and poorer terms and conditions are evident. Interestingly, the proportion of the workforce employed by the National Health Service is constant for UK-born and migrant workers (irrespective of their period of entry).

Demand for and Recruitment of Migrant Care Workers in Older Adult Care

Just under 50 per cent of providers of care for older people responding to our survey reported difficulties in recruiting UK-born care workers (58 per cent found difficulties in recruiting nurses). The difficulty of recruiting UK-born workers was the overriding reason for the recruitment of migrant workers given by these employers. Nine out of ten employers recruiting migrant workers undertake at least some action to recruit from the local labour market—i.e. only one in ten rely solely on overseas recruitment, including the recruitment of workers through the work permit channel of entry for senior care workers. Therefore, among the migrant care workers employed by these providers most were recruited after they had entered the UK.

> We don't specifically go out with the intention of just recruiting migrant workers, it just so happens that we have the majority of them apply to us. *(Manager of a home care agency in the South East)*

Recruitment difficulties were mainly attributed by providers to low wages and unfavourable working conditions in the sector, including shift work. Eighty seven per cent agreed that UK-born workers can earn more in other jobs and 74 per cent that they demand higher wages than those paid in social care. The role of low pay levels in pushing local workers out of the sector was also one of the major issues stressed in follow-up interviews. Providers emphasised the impact on pay levels of the budget constraints under which their organisations were operating because of their reliance on public funding:

> I'm sure if the local council paid a more reasonable rate we would be able to pay a more reasonable level of pay and that may well attract local staff to work on a Saturday or Sunday, at the night time.
> *(Manager of a residential care home in the South East)*

Tensions between budget constraints affecting care worker wages and the regulation of the quality of care were also indicated.

> The majority of our patients are funded by local authorities, and it would be lovely if the respective local authorities could give us a little bit more money to do the job up to the standards that the Care Commission would like to see us do the job to. [...] It's just an ongoing spiral of cost to [care] home owners, but we are not getting the income in at the other end. I think this is the main reason why wages are so low for everybody, including myself, within the care sector.
> *(Manager of a residential care home in Scotland)*

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

Although employers cited lack of suitable UK-born candidates available to work under the conditions prevailing in the care sector as the primary reason for recruiting migrant care workers, they also voiced widespread appreciation of migrant workers, reporting more advantages than challenges in relation to their recruitment and employment. Most of the providers employing migrant workers considered the advantages to include their willingness to work all shifts (82 per cent), 'good work ethic' (71 per cent), more respectful attitude to older people (68 per cent), and willingness to learn new skills (75 per cent). In follow-up interviews, employers emphasised migrants' social skills and care ethos, some comparing migrant workers positively with UK-born workers and job applicants. Thirty one per cent of the providers surveyed who employed migrant workers thought that the quality of their services had improved as a result of employing migrant care workers (while 62 per cent stated that it had not changed).

Employers also reported challenges related to employing migrants, notably difficulties concerning the limited English language proficiency of some workers (mentioned by 66 per cent of employers), particularly in relation to the provision of care to older people with poor cognitive abilities or sensory impairments (such as deafness or dementia). In addition to poor English language skills, employers interviewed referred to differences in accent, form of speech and intonation between

migrant care workers and users as presenting a challenge. A majority of employers also considered migrant care workers to require extra job training. Immigration regulations were reported as a further challenge by 50 per cent of employers, including delays in visa processing, restricted opportunities for applying for work permits and fear of penalties for employing migrants not allowed to work in the UK (Cangiano et al. 2009). Forty-one per cent of care providers also reported that migrant care workers were not always well accepted by their older clients.

Employment Conditions of Migrant Care Workers

The underfunding of the social care system and the related workforce shortages that shape demand for migrant care workers among social care providers also have implications for the conditions under which migrant workers are employed. While the social care sector is marked by low levels of pay overall, LFS data suggest that migrant care workers are over-represented among the lowest paid, as discussed previously. Among the migrant care workers interviewed in the research, some respondents referred to differences in levels of pay between lower paid care workers from Africa, Asia and Eastern Europe and higher paid British care workers.

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

Further issues concerning the 'underpayment' of migrant workers were indicated by some respondents, including the withholding of their wages by their employer and not being remunerated for overtime worked. The underfunding of social care, reflected in the low wages of care work (particularly within the private sector), may, therefore, not only shape demand for migrant workers but also inequalities in levels of pay between UK-born and migrant care workers. Moreover, it may encourage additional cost-cutting strategies by employers in terms of the 'underpayment' of migrant care workers.

The ability of employers to 'underpay' migrant workers in these cases was partly shaped by immigration controls. Care workers without permission to work in the UK (including asylum seekers and those who had overstayed tourist or student visas) were particularly vulnerable to exploitation due to fear and insecurity surrounding the irregularity of their immigration status. The reliance of work permit holders on their employer for their work permit[14] also made them highly dependent on their employers.

[14] Employers are responsible for applying for and renewing work permits for senior care workers. Although, in principle, work permit holders are entitled to change employer, this is dependent on a prospective employer re-applying for a new work permit.

The underfunding of social care and related workforce shortages also shaped other employment conditions for migrant care workers, including their hours of work. Migrant workers employed in residential and nursing homes referred to the reliance of their managers on them to work longer hours (by working full-time and overtime) and to work less favourable shifts compared with UK-born workers in order to address staffing gaps.

> My manager really tried hard to give us some weekends off but she couldn't because we have few other people who was employed or full-time... it was only few of us and it was Polish and Filipinos.
> (*Polish care worker who had been working in a nursing home*)

Those employed by home care agencies emphasised the lack of security of their hours of work, which could change from day to day, while those employed directly by older people or the families of older people referred to the lack of agreement on their hours of work, being expected to work on days off if needed. The characteristics of the social care system that shape the reliance of providers on migrant workers to deliver care to older people, therefore, have implications for inequalities in employment conditions in the care sector. These inequalities based on immigration status, nationality and race, which intersect with other inequalities based on gender, include the concentration of migrant care workers in the lowest paid types of care work, under poor terms and conditions.

The Quality of Care

We now turn to explore how the underfunding of social care simultaneously impacts on older people's and migrant care workers' experiences of the quality of care. The quality of care was described by older people in our research in terms of the *relational* dimensions of care, which have been emphasised more widely (e.g. Williams 1999). The need for communication—for a carer "to have a chat with", "who listens to me", who is "like a friend"—was given overarching importance by older people in the focus groups. Similarly, migrant care workers referred to the importance of these relational dimensions of care.

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

Staff shortages and workload pressures were experienced by migrant care workers and by older people as constraints on the development and continuity of their care relationships. In residential and nursing homes, migrant care workers reported long hours of work due to staff shortages. While working overtime provided a means to top up low wages, it also resulted in care workers being too tired at times to be attentive to the needs of residents. Staff shortages and the related workload pressures also limited the time available to migrant care workers to talk with residents, thereby inhibiting relationship building.

> If I don't have time, I can't develop a good relationship with them. I'm trying to give them as much time as I can but if there are no other staff, I just need to do other jobs.
> *(Polish care worker who was working in a residential home)*

Staff shortages not only limited time to talk with older people but to meet basic care needs adequately, including minimum standards of personal care.

> It's always cut down the staff. And if you cut down on staff, we can only do what we can at the end of the day... We used to have toileting in the morning, in the afternoon and before they go to bed. But now it's such that we cannot toilet them in the morning. So we get them up, and those who've got up early will stay until the shift at three o'clock because we can't do it. By the time we've finished getting some people up, it's lunch time already.
> *(Zimbabwean care worker who was working in a residential home)*

Likewise, staff shortages were associated with bypassing other regulations, reflected in migrant care workers' experiences of: lifting residents on their own because there were not enough staff available to assist them; being delegated nursing responsibilities to give medication to residents because nurses were too busy to do this; and not having adequate time to read or write notes on residents in care plans, or to carry out staff handovers to agency workers.

The rationing of resources in the provision of home care services similarly affected experiences of the quality of care. Time pressures were reflected in older people's experiences of home care workers arriving late, coming at inappropriate times, not staying for the full amount of time allocated to home care visits, or not completing care duties to a satisfactory standard. These experiences of 'rushed' provision negatively impacting on the quality of care have been found among the experiences of older adult care users more widely (e.g. CSCI 2008). In this research, migrant care workers employed by home care agencies similarly emphasised the inadequacy of the time available to deliver care. In some cases, where insufficient time was allocated to home care visits to meet the needs of older people, migrant workers reported staying beyond that time, where possible, in order to meet those needs.

> You can't be in hurry with this patient because he could hardly walk. He can't bend. And that's why I always stay longer because he needs a lot of help.
> *(Polish home care worker)*

Therefore, the provision of adequate time to care for older people was, in these cases, at the cost of those care workers who were willing to give their extra, unpaid time.

Temporariness of care work also limited the development and continuity of care relationships between migrant workers and older people. Agency workers, who were working in different residential homes for limited periods of time, referred to the difficulties of getting to know the older people for whom they cared in this context.

> Sometimes I forget their names. It's a shame but, you know, I can't remember every name when I'm working in 20 or 30 different homes and I meet hundreds of people. I'm trying to remember their names and to remember

them, their needs, what they like, what they don't like.
(Polish care worker employed in temporary work in residential homes through three employment agencies)

These effects of the rationing of resources on the quality of care were exacerbated by English language barriers between older people and some migrant care workers. Low levels of English language proficiency, as well as difficulties with understanding the accents of some workers, were identified by older people as one of the main challenges in relation to their experiences with migrant care workers. Care workers who lacked English language proficiency when they first started care work in the UK likewise referred to the communication difficulties that they had initially experienced. While these respondents had independently enrolled in English language programmes of local education providers, this provision was not always perceived as adequate in supporting English language learning, partly because of the limited amount of time they were able to give to attending classes due to the long hours that their jobs involved. Among those employed in residential and nursing homes, assistance from colleagues was identified as a principal source of support with English language learning, although this assistance also required time on the part of staff, which was not always available in the context of staff shortages and demanding workloads.

Conclusion

The principal driver of demand for migrant care workers in the UK that this research has identified is the underfunding of social care for older people, reflected in the low pay of care workers in this sector, as found by research in other European countries (Bettio and Plantenga 2004; Phillipson 2007; Simonazzi 2009), including research referred to by other authors in this special issue (Walsh and O'Shea 2009). The reliance of social care providers on migrant workers is, therefore, a symptom of the inability of the sector to recruit and to retain sufficient care workers under current pay levels and employment conditions. With a view to meeting not only existing but future demand for care services, a key priority, therefore, is to ensure that the pay, conditions and status of care work, as well as the opportunities for career development, make the sector more attractive to *all* workers. The relationship between the low wages paid by private sector care providers and their dependence on public funding poses significant challenges for the future social care system, given the inadequacies of existing levels of public funding and increasing demand for care provision.

The underfunding of social care has implications not only for demand for migrant workers among social care providers but for inequalities in the social care workforce. Gender inequalities in terms of levels of sectoral and occupational segregation in social care may increasingly overlap with inequalities based on immigration status, nationality and race. Pressures on contracted providers to deliver low-cost care may encourage cost-cutting strategies among providers that result in the employment of migrant care workers under lower levels of pay and poorer terms and conditions. While the focus of this article has been the dynamics within the social care system

that shape demand for migrant workers, these dynamics also interact with immigration policies. Immigration controls, by restricting the access of particular categories of migrants to the UK labour market, serve to create a supply of migrant workers who may be more 'willing' to accept low wages and poor terms and conditions than workers who are not subject to these restrictions (Anderson and Ruhs 2008). In the UK care sector, these include migrant care workers recruited under work permits as well as those who are employed irregularly.

The dynamics of the social care system that shape demand for migrant care workers simultaneously impact on the quality of care. UK policy has focused on improving the quality of care through better regulation and training and by giving older people greater 'choice and control' over their care (HM Government 2009). There may, however, be fundamental tensions between budgetary pressures and improvements to the quality of care if low-paid migrant care workers are expected to deliver care under conditions of workforce shortages. Moreover, improvements to the quality of care will be further constrained if new migrant recruits are not supported in accessing English language and other appropriate training provision.

Current demand for migrant care workers raises concerns in the light of future demographic trends. In the UK there is currently one care worker in older adult care for every 15 older people, and the projected increase in the number of older people means that, other things being equal, the size of the direct care workforce in the sector will need to grow by 400,000 over the next 25 years if this ratio is to remain at the current level (Cangiano et al. 2009). The question is to what extent the expansion of the workforce will rely on migrant workers. Our analysis suggests that, in the absence of a step change in public funding for older adult care, the sector will continue to rely on extensive recruitment of migrant care workers. Given the current and likely future constraints on public expenditure, particularly in the context of the economic recession, the implementation of expensive policies to make social care work more attractive to the local labour force, thereby potentially reducing the reliance of the sector on new migrant workers, seems an unlikely scenario.

Ongoing demand for migrant care workers in an ageing society, therefore, raises implications both for social care and immigration policies. Until recently, changes in immigration policy were undertaken with little awareness of the potential implications for the recruitment and retention of migrant workers in the social care sector, while social care policy equally lacked consideration of the contribution of migrant workers to the sector—the recent Adult Social Care Workforce Strategy surprisingly still makes no mention of their role (Department of Health 2009). The limited opportunities for non-EU workers to obtain a work permit in social care are set within the context of UK policy debate around immigration, which is largely affected by pressures to cut inflows of new migrants—particularly under the current negative economic trends—focusing on entry conditions for selecting highly skilled migrants. Consequently, the question of ongoing demand for migrant labour in the care sector brings to the fore broader questions concerning the ways in which migration policies shape processes of mobility of migrant workers into and within the sector. Greater attention to the interactions and tensions between social care and immigration systems is therefore needed in future research, as well as within policy making.

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