Migrant Care Workers in Ageing Societies:

Research Findings in the United Kingdom

Executive Summary

Alessio Cangiano, Isabel Shutes, Sarah Spencer and George Leeson

COMPAS (ESRC Centre on Migration, Policy and Society) | University of Oxford | 58 Banbury Road
Oxford | OX2 6QS | UK | Tel.: +44 (0) 1865 274711 | Fax.: +44 (0) 1865 274718
Email: info@compas.ox.ac.uk | website: www.compas.ox.ac.uk

This study focused on the current and future role of migrant (foreign born) workers in the care of older people. It investigated the current and potential future demand for migrant carers in an ageing society; the experiences of migrant care workers, their employers and of older people in residential and home care settings; and the implications of these findings for the social care of older people and for migration policy. Focusing on the UK, it was one of four country studies conducted between Spring 2007 and Spring 2009 in the UK, Ireland, the USA and Canada. The UK study was funded by the Nuffield Foundation and The Atlantic Philanthropies.

The study uses the collective term 'migrant' to refer to all foreign born workers, embracing migrants who have lived in the UK for some time as well as those who have recently arrived. However, much of our own data and analysis focus on 'recent' migrants: people who have entered the UK in the last decade (from 1998).

Sources of evidence and data are cited in the full-report*.

Method

The findings draw on analysis of national data sets on the social care workforce, including the Labour Force Survey (LFS) and the National Minimum Dataset for Social Care (NMDS-SC). New data was provided by a postal and online survey, between January and June 2008, of 557 employers of care workers, including managers/owners of residential and nursing homes and home care agencies, followed by 30 in-depth telephone interviews with selected participants. Face-to-face interviews were also conducted between June and December 2007 with 56 migrant workers employed by residential or nursing homes, agencies or directly by older people or their families. Five focus group discussions were conducted with 30 older people, including current users of care provision and prospective care users. Projections of the future demand for care workers in older adult care were carried out, focusing on the potential contribution of the migrant workforce. Briefing papers were commissioned from experts on the structure of the health and social care systems and trends in the social care workforce; and a series of seminars and discussions were held with individuals working in the sector or as policy makers. An international advisory group provided guidance and feedback on the draft report.

Background

Social care

Informal care by families and friends remains the dominant form of care provision for older people. Social care services have been the focus of ongoing reforms including a shift towards home care, increasing procurement of care services from independent providers, and targeting of public expenditure on those older adults with greatest needs. A key objective of government policy is the extension of user choice and control over the care they receive, including use of direct payments and personalised budgets to employ care staff in their own home as well as to purchase services.

Regulation of care services and of the workforce has been one of the ways in which the Government has recently sought to raise standards of care. The Care Quality Commission is responsible for inspecting care homes and agencies in England to ensure compliance with statutory regulations and National Minimum Standards, including the percentage of qualified care staff employed in each care home and that induction training is provided. Registration of some care staff is being introduced over time, along with improvements in training provision.

In England 4% of people aged 65 and over are receiving institutional care (residential and nursing care homes), but the proportion is significantly higher (11%) among the 'older-old' (aged 80 and over). A further 9% of the total older population receive some form of home based care. 92% of residential care places for older people (2007) are provided by the independent (private and voluntary) sector. In 2006 over 60% of home based care and nearly 40% of residential care services for older people were thought to be wholly or partly funded by the public purse. An estimated 450,000 older people have some shortfall in their care provision.

Eighty-eight per cent of all care workers is women and 17% from ethnic minorities. About 74% of the adult care workforce is in the independent sector and 15% work for (but are not necessarily employed by) individuals receiving direct payments. 71% of care workers in adult social care (642,000 individuals across the UK in 2006/7) is estimated to be working with older people. The median gross hourly pay for care workers (excluding senior care workers) in adult services, which has risen relative to other low wage occupations in recent years, 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. Turnover in care jobs is higher than in most other occupations but significantly varies across the care sector (in England 9.6% in the statutory sector, 15.8% in the voluntary sector and 23.6% in the private sector in 2007/8). The vacancy rate for care jobs is nearly double that for industrial, commercial and public sector employment, despite some recent

contraction in unfilled vacancies resulting from the economic downturn.

The ageing population is a key factor in the expected growth in demand for care. Twenty-two per cent of the population is projected to be aged 65 years and over by 2030, up from 16% in 2007. In particular the number of those aged 80 years and over will double to just under 8% of the population by 2030. According to a recent study, demand for informal care for older people is projected to exceed supply from their adult children by 2017, potentially mitigated to some extent by more older people living with their spouses. Skills for Care estimates that the adult social care workforce in England may need to increase from 1.39 million (2006) to a possible 2.5 million by 2025.

Migration

Migration policy has also been the focus of recent policy change, with implications for the opportunities for migrant workers to work in the care sector. While the National Health Service historically relied heavily on migrant doctors and nurses, improvements in pay and conditions, training provision and 'Return to Practice' schemes have meant that it is currently able to fill most posts from within the UK. This strategy has not hitherto been pursued in social care.

There is no migration entry channel to work in care except limited entry for senior care workers, formerly with a work permit and now through Tier 2 of the points system. Nurses could also formerly enter through the work permit system for shortage occupations. After EU enlargement in 2004, East European migrants became a source of care workers, 23,580 registering that employment by March 2009. Migrants who enter through non-labour market channels but who are allowed to work, such as refugees, international students and spouses, can also take up jobs in the sector.

While policy on migration is developed in the Home Office, policy on social care is the responsibility of the Department of Health. The evidence suggests some past lack of coordination. The Migration Advisory Committee has recently provided a forum for reviewing evidence and advising government on skill shortages. A Home Office decision in 2008 to further restrict senior care workers' entry (later relaxed) concerned employers and trades unions. Reform of entry rules for international students and working holiday makers may reduce the availability of young people from abroad to work in the sector.

The UK has no integration strategy for new migrants other than refugees. Elements of a strategy are in place, such as the provision of English language teaching, but attendance at classes can be difficult for those doing shift work.

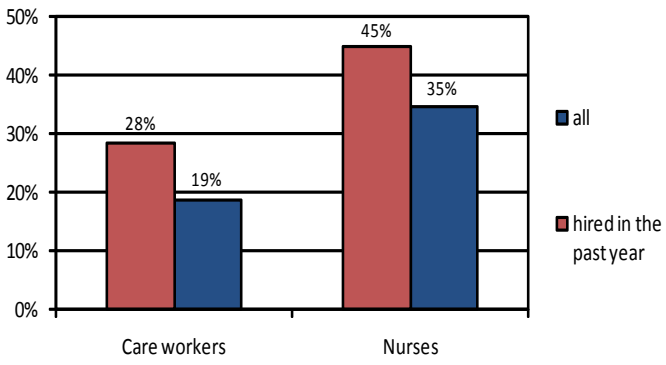
The UK has laws providing some protection for the rights of workers, including responsibilities on employers in relation to discrimination and harassment. Where an older person directly employs a care worker the overlapping roles of care user and employer have implications that emerge in our findings.

Findings

The foreign born workforce in older adult care

Our survey showed that migrant workers account for 19% of care workers and 35% of nurses employed in the care of older people in the UK and, significantly, 28% of care workers and 45% of nurses recruited in 2007 (figure 1). These figures are consistent with estimates for all care workers provided by the LFS, according to which the proportion of foreign born care workers was 18% (Oct-Dec 2008). LFS data also shows that the proportion of foreign born care workers has more than doubled over the last decade, and recent migrants (people who entered the UK in or after 1998) make up 12% of the care workforce as a whole. In London more than 60% of all care workers are foreign born. Over half of recent migrant care workers are less than 35 years old and 31% are men.

Figure 1 – Proportion of migrants among care workers and nurses in older adult care, 2008



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

Source: COMPAS survey of employers

The most frequent countries of origin of recent migrant care workers employed in the care sector (2007/8) are Poland, the Philippines, Zimbabwe, India and Nigeria. However source countries have changed significantly over time.

Our survey confirmed that most foreign born care workers are recruited *after* they are already in the UK. There is no data on the immigration status of the migrant care workforce when they entered the UK. We tentatively *estimate* from our survey that 40% of foreign born care work-

ers currently working in the UK are British nationals or permanent UK residents (including refugees, for instance, who have acquired that status), 20% are EU nationals, and just under 20% are work permit holders (including some domestic worker visas). The rest include students and spouses in particular, but also working holiday makers and people on ancestral visas. 5 out of 56 migrant carers interviewed for this study were currently, or had in the past been, employed without permission to work in the UK. Neither our sample nor other data enable us to estimate the extent of irregular employment in the sector.

Recent migrants, who are on average younger and have less UK work experience than the UK born workforce, are disproportionately found in the private sector (79%), where wages are lower than for those employed by local authorities (where 5% of recent migrant carers are employed compared to 23% of UK born carers). LFS data, based on self reported wage levels, suggested that a significant proportion of care workers (close to one in five) may be paid *below* the National Minimum Wage, with recent migrants most often in that position. However, sources of wage data collected from employers (ASHE and NMDS-SC) provide significantly lower estimates of the proportion of care workers paid below statutory pay levels, making it difficult to make a definitive assessment. Recent migrants are also the most likely to work all shifts, to have temporary contracts and to be enrolled in education or training (including students undertaking courses not related to social care).

Employment of foreign born carers in older adult care

Fifty-eight per cent of employers in our survey (January – June 2008) reported difficulties in recruiting nurses to work with older people and just under 50% difficulty in recruiting care workers. The overriding reason for the recruitment of migrants given by employers was the difficulty of finding UK born workers. Nine out of ten employers recruiting migrant workers undertake at least some action to recruit from the local labour market, while only the remainder rely solely on overseas recruitment.

"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 attributed by employers to low wages and poor working conditions in the sector and associated with low rates paid by local authorities subcontracting care provision, a concern shared by the Low Pay Commission.

"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)

Recruitment difficulties were emphasised most strongly by care organisations employing nurses. There is a significant overrepresentation of foreign born nurses in older adult care relative to better paid, higher status jobs in the NHS. The widespread perception of a shortage of UK born nurses in the provision of older adult care contrasts with the Government's confidence that the NHS can rely on domestic training and recruitment of nurses, reflected in curtailment of nursing work permits.

Although employers cited recruitment difficulties as the primary reason for recruiting migrant staff, they voiced widespread appreciation of migrant care workers, reporting more advantages than challenges in relation to recruitment and employment. Advantages cited included their willingness to work all shifts (82%), a 'good work ethic' (71%), a more respectful attitude to older people (68%), and willingness to learn new skills (75%). In interviews, employers emphasised migrants' social skills and care ethos, some comparing migrant workers positively with UK born workers and job applicants.

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

(Manager of a residential care home in the South East)

A majority of employers (62%) stated that the quality of care provided by their organisation had not changed as a result of employing migrants. 31% thought that the quality of their services had improved.

Employers also reported challenges related to employing migrants, notably English language proficiency (mentioned by 66%), particularly in relation to older people with poor cognitive abilities or sensory impairments (such as deafness or dementia).

"It's communication. This home looks after frail and elderly people. Over 60% of our patients have some form of a dementia. It's hard enough for people with dementia, or even if I look at it the other way around, it's hard enough for staff to understand what is going on in dementia people's heads, what they want, what they need. Now it is even more difficult for somebody who cannot understand the language very well."

(Manager of a private nursing home in Scotland)

In addition to poor knowledge of English, a carer's accent,

their form of speech and their intonation were thought to present a challenge for care users. A majority of employers also considered that migrant carers required extra job training. Immigration rules were a problem for 50% 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.

Migrant carers' reasons for entering care work and 'willingness' to accept unattractive working conditions can reflect constraints related to their immigration status, the difficulty of accessing other types of work in the UK and the need to support themselves and families in the UK or abroad.

"I'm stuck, even if I want to move. I said to myself, if I move to another employer that might affect my status after four years, to apply for leave to remain or for residency or even citizenship. So, I just stick with the employer."

(Filipino senior care worker, nursing home)

Migrants subject to immigration controls are more likely to remain in the job for longer than EU workers who are allowed to seek alternative employment. Coupled with the fall in recruitment of EU care workers, this raises questions about the implications of any higher expectation of reliance on EU workers in the future for continuity of care provision.

Migrant workers found caring for older people to be demanding but also rewarding in the context of the close relationships that they were sometimes able to develop with the people for whom they cared.

"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)

Quality of care

Employers, older people and migrant workers emphasised the importance for older people and staff of the relational dimension of care: of communication, warmth, respect, empathy, trust and patience. The principal challenges for providing this quality of care were those reported in previous studies: staff shortages, the limited time available for workers to provide care and develop personal relationships (including insufficient time allocated to home care visits), and lack of continuity in care.

Positive relationships between older people and migrant care workers were evident in particular where they had had time to develop a relationship.

"[Flora] is wonderful; I've had her four years… We are more friends than anything now, she is lovely, she really is. She is a ray of sunshine. As soon as she comes in the door it's all laughs with her. She's got a terrific sense of humour. I don't know what part of Africa she comes from, but she speaks very good English and she's very good."

(Focus group participant, home care user)

Where there were language and other communication barriers, these were a constraint on the quality of care. However, the proficiency of migrant carers in languages other than English did in some contexts help to meet diverse language needs of older people. Lack of knowledge of the customs of older people, for instance in relation to preparation of food and drink, were also experienced as a problem, suggesting a lack of sufficient induction training. A lack of training and support concerning the health related needs of older people, including dementia, was evident in the experiences of live-in care workers employed directly by older people.

Shortage of staff and of time allocated to care tasks and home visits were a challenge for all care staff, with an impact on older people's experiences of care. In relation to migrant carers it was in some cases related to negative attitudes of care users towards them.

Discrimination and access to employment rights

Interviews with employers and migrant carers, as well as discussions with older people, provided evidence that discrimination is experienced by some migrants working in the care system, in their working conditions, treatment by co-workers, and relationships with care users. Some migrant workers were being treated less favourably than other care staff in relation to longer hours of work, less favourable shifts (including weekend work), lack of guarantee of minimum hours (and hence pay), unpaid overtime, distribution of less popular tasks, lower wages, employers' non payment of tax and National Insurance (affecting migrants' social protection) and withholding of wages, and in relation to training opportunities, promotion, complaints, disciplinary and dismissal procedures. Migrant carers identified nationality or race as the overt basis of discrimination, or immigration status.

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

(Zimbabwean live-in care worker, referring to experiences working in residential homes)

Live-in care workers face particular challenges and have fewer employment rights. Those working directly for older people were particularly vulnerable in relation to time worked and pay.

"There's no agreement on that [hours of work]. I work continuously, continuously, continuously, provided I'm in the house, you

know, continuously, continuously."

(South African live-in care worker employed directly by an older person)

Forty-one per cent of employers reported that migrants were not always well accepted by their clients. Migrants also referred to negative attitudes and behaviour of some older people towards them. In some cases older care users made overt references to race, colour and nationality in negative comments about and towards migrant care workers, including verbal abuse (particularly towards workers from African countries). In other cases, negative attitudes reflected concerns about language skills or knowledge of customs.

"There's a resident that can say, 'I don't want black people. Don't touch me. You are black. Go back to your country'."

(Zimbabwean care worker, residential home)

"A lot completely refuse, they don't want them in the room and ask them to go away and they are quite rude to them...It's quite difficult because some are quite vocal and there's not an awful lot I can say really."

(Manager of a residential care home in the North West)

Employers and migrants said that the situation tended to improve once the older person got to know their carer.

"A number of our residents are apprehensive and on occasion have been rude and out of line. But once they get to know the staff member as a person rather than that they are from a foreign country, then that problem seems to disappear."

(Manager of a residential care home in the South East)

Some employers and agencies were unsure how they should manage this situation. They had a responsibility as managers of a business and as care providers for older people to respect their wishes, but also had a responsibility not to discriminate against a job applicant or employee. In situations where an older person refused to be cared for by a migrant worker or was verbally abusive, managers occasionally spoke to the older person about their treatment of the carer. Others moved the carer to work with other clients. In some cases migrants were expected to continue to work with the older person against their wishes. Managers had often received no training on how to handle this situation. Older people directly employing a carer in their own home may be least likely to have received guidance in this respect.

Migrants similarly reported little access to information or advice. Awareness of a right to freedom from discrimination did not include awareness of how to claim redress, except for the minority who were members of a trade union. While access to employment rights is also an issue for UK born care workers, migrants' lack of familiarity with the system, language barriers and anxiety over immigration status can present additional challenges.

Future demand for migrant carers

The study explored the potential future demand for foreign born care workers in older adult care. Projections (*not* predictions) were carried out of the total workforce that could be needed to meet the demand for care of older people to 2030, assuming constant dependency care ratios (i.e. the ratios of care workers and nurses to the older population). The total number of care workers working in older adult care would need to increase from an estimated 642,000 in 2006 to 1,025,000 in 2030, and the total number of nurses in older adult care from 60,000 to 96,000.

We provide three scenarios on the potential contribution of foreign born care workers to the future development of that workforce. These are *not* projections for future levels of *im*migration but for the stock of foreign born carers working in the care system (of whom, as now, the majority may come to the UK for other purposes and be recruited *within* the UK).

In our medium scenario, which assumes that the *percentage* of migrant carers in the workforce will remain constant (19%), the stock of migrant carers working with older people would need to increase from 122,000 in 2006 to 195,000 in 2030, an average annual growth of around 3,000 or 2.5%. This would represent a *slowdown* in the short term in comparison with the growth of the foreign born care workforce in recent years but still a considerable recruitment challenge for the care sector. Similarly, to retain the proportion of migrants in the nursing workforce in older adult care the stock of foreign born nurses would need to increase from 21,000 in 2006 to 34,000 in 2030 – a 2.5% annual average growth.

In our low and high scenarios, useful for comparative purposes, the entire additional need for care workers and nurses would be met, respectively, by UK born or foreign born staff. If the growth in the workforce were met entirely by UK born staff, the proportion of foreign born care workers would decline to 12% by 2030. If the additional care workforce were to be provided entirely by foreign born workers, an unlikely scenario, the foreign born workforce would have to grow by an average of 16,000 per year. Under this assumption, by 2030 one in two care workers working with older people would be foreign born (similar to the current proportion of all social care workers in London).

Actual demand for new migrants will depend on a range of factors not addressed in this study including labour market conditions and the impact which steps taken to

raise the status, pay and conditions of care work may have on the extent to which suitable people in the existing workforce, including men, are attracted to care jobs.

LFS data shows that the recent expansion of the care workforce has in part drawn on people not previously working in the care sector. The propensity to take up care jobs has been limited, but higher among those formerly providing informal care (4.8% of those moving to employment in the last year) or unemployed (4.3%) than among students entering the labour market (1.5%) or people previously in other occupations (1.6%). There is also some evidence that the domestic supply of workers available to take up care jobs may increase as a result of redundancies in other sectors and reductions in household income pushing inactive people into work. However, care sector employers will not necessarily be willing to recruit from this pool if they consider applicants who lack experience of care work or appropriate skills unsuitable for appointment.

Evidence from recent unemployment data and from employers interviewed in Spring 2009 suggested that, because of the relative stability in the demand for care, the social care workforce is less exposed to the economic slowdown than those in other less skilled occupations. However, unemployment of care workers is rising and the number of vacancies has reduced in 2009.

While acknowledging the undesirability of reliance on migrant workers as an alternative to raising wages and improving conditions in the sector, we conclude from this analysis that, in the absence of a step change in public funding for care provision, the care sector is likely to continue to need to rely on a significant and potentially growing number of migrant care workers.

Conclusion

The reliance of the independent care sector in particular on the migrant workforce has considerably expanded over the past decade. Foreign born care workers, including recent migrants, are making a significant contribution to care provision for older people, particularly in London.

The principal reason private care providers recruit migrants is the difficulty of finding sufficient suitable UK born staff, reflecting the low pay and working conditions in the sector. These are in turn related to the lower rates paid by local authorities for care commissioned from the independent sector, and rates which individuals and families can pay, limiting employers' capacity to improve pay levels.

Employers think positively of the contribution migrants make, including a strong 'work ethic'. It is important to ensure that this does not extend to exploitation of migrants' 'willingness' to accept poor working conditions because of financial and/or legal constraints. Better data on wage levels and conditions in the sector is needed to establish the extent to which migrant carers are experiencing unacceptable treatment in the workplace, including race discrimination, and to ensure that care is not being provided at lower operating costs, at the migrants' expense, than would otherwise be the case.

Likewise, a lack of information on the immigration status of migrant workers in the sector, for instance the proportion of international students working to support unrelated study, precludes a comprehensive analysis of the impact of recent reform of immigration regulations on future availability to work in the sector. Significant improvements in the coverage and quality of the available information may derive from the introduction of questions, currently being piloted, identifying migrant workers in the NMDS-SC.

High vacancy and turnover rates and the 'willingness' of migrants to accept low pay are not the only factors shaping the recruitment and employment of migrant care workers. Their skills, as reported by employers, are contributing to the quality of care provided. Their overall contribution should be acknowledged in public and policy debates.

The evidence on the factors influencing quality of care underlines the importance of creating for all workers, and particularly for migrant workers (given their potential language barriers and lack of local knowledge of customs), working conditions that facilitate communication and relationship building. The working conditions of migrant workers and the quality of care for older people are thus related issues. The findings suggest a need for migrant entry conditions to facilitate (not require) stability of employment to allow continuity in the care relationship; to facilitate access to language tuition and professional development (on which there are examples of good practice); and for induction arrangements that include everyday customs and the colloquialisms that older people may use to refer to their health and personal needs.

The negative attitudes of some older people towards migrants, particularly before a relationship has had an opportunity to develop, present a challenge on which employers, including older people, need guidance and on which migrants lack advice and support. There can be a tension between the personalisation agenda, promoting user choice and control, and the responsibility not to discriminate in the appointment or treatment of the carer.

Looking to the future, the ageing population means that the size of the social care workforce will need to grow

significantly. The question is the extent to which the expansion of the workforce will rely on migrant workers. The key factors are likely to be pay and working conditions and the effect of new initiatives to improve the status of care work. The impact of the recession on the availability of suitable recruits, and particularly its potential consequences in the medium and long term, are unknown at this stage.

The solutions to the challenges that we have identified thus lie, fundamentally, in the social care system. The increasing reliance on recent migrants is a symptom of the structural and funding challenges the care system is experiencing and, in the long term, migrants cannot be the solution to those problems.

Our findings nevertheless suggest that, in the absence of a step change in public funding for care provision, the care sector will continue to rely on a significant number of migrant care workers. The role of migrants should therefore be planned, not an unintended consequence of pay and working conditions unattractive to other job seekers; and the implications of their contribution should be addressed – not ignored – in the consideration of future immigration and social care policies. There needs to be greater coordination between government migration and social care policies than has been evident in the past, to the mutual benefit of employers, older people and the migrants who care for them.

In this and other respects the findings and conclusions of the parallel US, Canadian and Irish studies in this project bear striking resemblance to our own; not least the conclusion of the Canadian report that 'the relative invisibility of the conditions of eldercare is mirrored in the work conditions of immigrant care workers' and of the Irish report that 'it is impossible to separate the fate of migrant care workers from that of older people and their families'. Reform in both the social care and immigration systems must proceed in tandem if the challenges we have identified for older people and for migrant workers are to be resolved.

Recommendations

1. Increase the funding and status of care work

The Department of Health's social care review must address the need to ensure that the pay, conditions and status of care work, and the opportunities for training and career development, make the sector more attractive to locally resident men and women. Recent evidence from a BBC poll that only 2% of the public want social services budgets to be protected compared to 73% prioritising health and education budgets, regrettably suggests that the Government may not face voter pressure to do so.

The 'low skill' categorisation of most care (as opposed to nursing) roles is problematic, reflecting the low level of training, lack of recognition of soft skills (the importance of which is so strongly highlighted in this study) and predominance of women in the workforce. Improvements in training, qualifications and pay would contribute to greater public acknowledgement of care workers' social contribution.

Initiatives to make the sector more attractive could explicitly address the gender imbalance in the care workforce, tackling the stereotype that caring is women's work. The Government's recent Adult Social Care Workforce Strategy includes measures intended to raise the status of care work and recruitment to the sector, including funding for 50,000 social care traineeships and extension of registration to some home care workers, but will need to be backed up by improvements in pay and conditions to make a sustainable difference.

2. Retain a migration entry channel for senior care workers

We share the view of the Migration Advisory Committee (MAC) that it is not desirable in the long term for migrant workers to be recruited from abroad to fill posts which, because of poor pay and conditions, are unattractive to those already within the UK. In the short term, however, further restricting the entry channel for senior care workers would exacerbate the difficulty employers are experiencing in filling these posts and hence their ability to provide care services. The MAC advice that entry be permitted for senior care posts fulfilling certain criteria is thus a necessary interim measure and reduction in the required wage threshold to £7.80 appropriately reflects prevailing conditions in the care labour market.

3. Monitor the long-term need for a migration entry channel for lesser skilled care workers

There is no case for activating a new entry channel for less skilled care workers in the immediate future. Migrants recruited on the local labour market are still providing a significant workforce for these positions, the Government has recently taken some steps to boost local recruitment, and the current rise in unemployment may lead to more applicants from the UK born workforce, although not all may be considered suitable for care work.

Our projections show, however, that the ageing population will require a significantly larger care workforce. Even if the percentage of migrants was to remain constant, a greater number of migrant carers would be needed. EU migration has declined, and there can be no confidence that wage levels in the sector will rise sufficiently to meet all of the growth in demand from within the UK. The impact of recent changes in entry rules for non labour migrants is a further relevant factor. The Home Office needs to recognise the contribution within the care workforce of those migrants who enter for other purposes – as spouses, refugees, students, domestic workers, working holiday makers or on ancestral visas. Changes in immigration rules could affect the availability of students, in particular, to fill these posts.

A system to monitor labour shortages in care work, and the contribution which different categories of migrants are making in meeting those shortages, is needed; perhaps by expanding the Migration Advisory Committee's remit to cover these less skilled posts.

If in the long term there is an unmet demand for less skilled care workers government needs to consider allowing direct entry for migrants to take up these jobs. The alternative, if employers cannot recruit legal migrants to maintain care services, could be an increase in migrants working without permission. It would not be appropriate to use the (currently dormant) Tier 3 to create a channel for temporary workers. Temporary staffing is not a desirable option in this sector. It would run counter to the need for continuity in care, older people and employers being constantly faced with new staff adapting to their roles in a context where understanding cultural nuances and particularities of language can take time to acquire, and relationships with older people time to develop. A recent survey confirmed that the UK public also prefers a system of permanent immigration to the rotation of people on a temporary basis. If there is a need for a legal entry channel for care workers to meet labour shortages, it should be on a basis that allows long term employment, leading to eligibility for permanent residence. This would also help to ensure that migrant care workers have access to the same rights as their British counterparts.

4. Improve Government coordination and communication with employers

Until recently, reform of the migration system was being undertaken with little awareness of the potential implications for the staffing of the care sector; while social care debates equally lacked consideration of the potential impact on the demand for migrant workers. The recent Adult Social Care Workforce Strategy surprisingly still makes no mention of their role. The concern among care sector employers, recruitment agencies, trades unions and the Department of Health in 2008, when it became clear that access to the UK for senior care workers was to be further restricted, and that changes in the rules for working holiday makers and students could also restrict the supply of care staff, drew attention to the need for greater awareness among policy makers of the implications of reforms in their respective fields. Government needs to ensure that there are structures in place that enable migration policy to take account of staffing needs in the care sector and of government objectives in relation to up-skilling the workforce, continuity of care and protection of vulnerable workers.

Most employers had faced procedural difficulties in securing permits and visas for senior care workers and in employing other migrants subject to immigration controls. These included delays, inconsistency in outcomes, and difficulty securing information from the UK Border Agency (UKBA) on whether staff who applied from within the UK had permission to work. These challenges were exacerbated by the difficulty of keeping up with frequent changes in the immigration rules. Given the penalties for employing a carer not allowed to work, arrangements should be in place to allow employers to check eligibility without undue delay. Delays in securing Criminal Record Bureau clearance is a further obstacle in the recruitment process which needs to be addressed.

5. Promote integration and access to long term residence and citizenship

Consideration needs to be given to fostering the integration of migrant carers not only within the labour market but within the wider community. It is not in the interests of older people, nor of employers, if carers face unnecessary barriers to integration and are discouraged or prevented from remaining in the UK. In that context, their situation should be included within any future development by the Home Office or Department for Communities and Local Government of an integration strategy for newcomers. Furthermore, if the Government proceeds with its intention to 'speed up the journey to British citizenship and permanent residence' only for those who demonstrate 'active citizenship' through voluntary work in the com-

munity, it should recognise the significant contribution that migrant care workers are already making and that it would neither be appropriate nor feasible in practice for many to make a further voluntary contribution given the long hours and shifts that they are already working.

6. Ensure access to language and skills training and guidance on cultural norms

Language and the colloquialisms and nuances of personal communication, coupled with understanding of cultural norms relating to personal care, can be a significant challenge for migrant workers. Notwithstanding examples of good practice, the language and induction training currently available would seem from the evidence to be insufficient. Migrants are often employed by small care providers with few staff: employers who are not in a position to run language classes or produce the kind of induction literature that migrant carers need. Government and skills agencies need to ensure that such provision is made and guidance material available; and that it reaches those workers working shifts in a '24 hour care' environment, with low capacity to access regular classes or to pay tuition fees.

The exclusion of non EU migrant care workers from publicly funded NVQ training until resident for three years in the UK is counterproductive, as care users benefit from that training. NVQ qualifications also represent an opportunity for career development which is likely to help with retention. Government may want to reconsider this restriction in light of its overarching objective of improving skill and qualification levels in the sector.

7. Care sector organisations should address issues relating to migrant care staff

The Care Quality Commission has responsibility in England for supervising compliance with standards in the care sector, including induction, training and the ethos of care homes. We recommend that it consider the implications of our findings for future standard setting for residential and domiciliary services, and within the focus of its inspections and thematic reviews. Statutory and independent sector organisations engaged in older adult care equally need to take account of the significant number of migrant carers in the sector and of the issues which this raises.

There is a broader need to ensure that care staff have access to accurate information on the conditions attached to their immigration status, their rights at work and where they can access further information and support. In this trades unions and professional associations in the care sector have a key role to play. There is also a need for government to review certain restrictions on those rights, for instance the ambiguity of live-in workers' rights under the Working Time Directive and minimum wage regulations and the de facto exclusion of irregular workers from the protection of discrimination law.

Those migrant care workers who enter through the points based system are working for employers who must, since 2008, also be licensed by the UKBA to sponsor their entry. The process of applying for a license includes satisfying the UKBA that the organisation meets certain criteria including, in the care sector in England, that it is registered with the Care Quality Commission. Although resource constraints appear to have meant limited inspection of employers before the license is granted, the UKBA could use this process to secure agreement to broader conditions such as ensuring that migrant workers have access to the advice and language training that they need.

8. Address the prevalence of discrimination and harassment

The frequency in migrant carers' reports of less favourable treatment in pay and working conditions suggests a systemic inequality which should be investigated. There is also a need for the appropriate authorities to respond to the hostility some older people are expressing towards migrant carers and the concerns of managers in this regard.

We suggest that the Care Quality Commission and the Equality and Human Rights Commission, in consultation with employers, unions and migrant representatives, should consider how this might be addressed, including ensuring that managers and care staff have appropriate training on equal opportunities in employment and service provision, and written guidance on best practice to refer to; that there is a mechanism in each work place for workers to have their concerns addressed appropriately; and that older people and their families have guidance on their responsibilities as employers in home care. Those care users and families who are not initially comfortable with care provision by migrant workers also need to be helped to understand the essential contribution which migrants now make to care services and that staff, like older people, have a right to be in an environment that respects their dignity and self worth.

A further opportunity to ensure that the rights of carers and of older people are protected arises from local authorities' statutory duty to promote equality of opportunity and good relations, and to use their leverage through commissioning of care services to ensure that care providers also have procedures in place to do so. Local authorities should also ensure that in their relationship

with older people and their families through direct payments and personalised budgets they provide clear guidance on their responsibilities towards carers, and could play a mediation role should any difficulties arise in the employment relationship.

9. Monitor the implications of the direct employment by older people of migrant home care workers

The emphasis on extending user choice and control in home care, and the consequent growth in the direct employment of care workers by older people and their families, has implications for the protection of older people and of care workers. Many of the safeguards in place for care homes and home care agencies, including inspection by the Care Quality Commission and requirements in relation to criminal record checks, do not apply where carers are directly employed. Intrusion by the state into private homes is a sensitive issue and not to be undertaken lightly. Nevertheless, our findings suggest that consideration should be given to the consequences of this development and the potential need for additional safeguards should be kept under review.

The findings also point to the need to improve access to information and advice for older people and their families, particularly those who take on the responsibilities of an employer, and support in fulfilling the additional responsibilities this imposes. This underlines the need for external intermediaries, such as local authorities contributing to the cost of care, to have a guidance and support role in direct employment relationships, ensuring that older people, their families and migrant workers are aware of their respective rights and responsibilities.

10. Foster public recognition of the invaluable contribution of care workers

The contribution which care workers are making to the care of older people is invisible to the majority of the public who are not in regular contact with the care system. Within a negative political climate, it is easy for the public to overlook the particular contribution which migrant care workers are making, doing a demanding job for low financial reward. As debates on reform of the care system are taken forward, the essential contribution of the care workforce as a whole, and of migrant carers among them, in providing quality care for older people, should be given greater public recognition and – along with the focus on the rights of older people – lie at the heart of proposals for reform.

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The authors

Dr Alessio Cangiano is a demographer at COMPAS, Oxford University

Dr Isabel Shutes is a researcher in social policy at COMPAS, Oxford University.

Sarah Spencer is Deputy Director at COMPAS, Oxford University.

Dr George Leeson is Deputy Director of the Oxford Institute of Ageing, Oxford University.

Please visit the website of the Centre on Migration, Policy and Society, University of Oxford, at http://www.compas.ox.ac.uk/research/labourmarket/migrantcareworkers/migrantcareworkers

* The full report, Migrant Care Workers in Ageing Societies: Report on Research Findings in the UK, by Alessio Cangiano, Isabel Shutes, Sarah Spencer and George Leeson, published by Compas on 25 June 2009, is available as a free download from:

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Centre on Migration, Policy and Society (COMPAS)
University of Oxford, School of Anthropology,
58 Banbury Road, Oxford, OX2 6QS, UK.

T: +44/0 1865 274711
F: +44/0 1865 274718
E: info@compas.ox.ac.uk
W: www.compas.ox.ac.uk

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