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Stepping Stones & Entrapments:

Care work as inclusion and exclusion for migrants to the EU with especial focus on the UK

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Introduction

Working as a carer has the potential to function as a 'stepping stone' or an 'entrapment' for newcomers to the EU (Williams, 2007). Care work can enable migrants to develop careers in dynamic social services, improve language skills and integrate smoothly into new societies (Ibid). Migrant workers are increasingly vital to providing care for the elderly (and other dependents) during this period of demographic ageing (Ungerson, 2004, Lyon and Glucksman, 2010). Traditional caring is being reworked across Europe with different forms emerging across the continent, especially as women engage increasingly in employment outside of the home and are less available to provide care to family members (Taylor-Gooby, 2004). The involvement of migrants in care-provision is, therefore, becoming more common across the continent and, in this way, migrant care workers are becoming integral to European societies. Simultaneously, however, the nature of the work can preclude effective integration, representation or recognition. With its long hours, low pay and hidden location in homes or institutions, migrant workers remain highly vulnerable to social exclusion.

This paper will present the preliminary observations from a first round of interviews with migrant care workers in the UK. So far, the author has conducted eight interviews with South-East Asian carers, discussing their experiences of migrating to the UK, taking up work in the elderly care sector and their reflections on care provision in Britain versus in their birth countries. Ultimately, these stories will be combined with others from carers of African, Caribbean and Eastern European origin in order to capture an insight into the lives of migrant care workers in the UK. These in turn will comprise puzzle-pieces in a wider jigsaw being compiled by Weicht et al (forthcoming) at Utrecht University of migrant care worker experiences across the EU (in a study to be titled 'Caring Labour in a Migrating World).

The first part of this paper will discuss the potential for migrant carers to face exclusion, and indeed note opportunities for inclusion. Secondly, migrant carer social exclusion will be considered in pan-European perspective, with thumbnail sketch case studies from several European countries being presented. In this section, the reader will be introduced to Cash for Care policies which comprise one way for governments to facilitate service provision for their ageing populations. The core of the paper, however, will focus on the British case study and a second example of elderly care provision; the residential care home. In this third section, observations from the initial round of interviews will be grouped into themes of inclusion and exclusion so that the reader may gain an insight into the 'stepping stones' and 'entrapments' faced by carers working in the UK care industry.

Part I: Identifying emerging forms of social exclusion

Migrant carers potentially face social exclusion on two counts, dependent a) on their migrant status and b) on the constraints of their work demands. Recent arrivals, particularly those with precarious legal status lack recourse to traditional 'hard power' which is present in key democratic institutions such as governments, parliaments and trade unions. Bonoli (2005) observes that this makes migrants significantly more likely to be vulnerable to social risks and much less likely to be able to access supportive services provided by the welfare state. Furthermore, even where members of minority groups are *present* in traditionally powerful institutions, they do not automatically *represent* the interests of more vulnerable members of their community (Ibid). Representation has typically been achieved in the historical development of welfare states through large collectives of the electorate wielding 'power resources' which reflect their democratic weight and solidarity within relatively cohesive communities (Korpi, 2006). This avenue is less open to migrant minorities who simply might not achieve the critical mass required to exert force of power resources on the political, policy-making arena (Bonoli, 2005). Taylor-Gooby (2004) notes that as these groups' specific needs (such as additional provision of information regarding social services, education, language tuition etc.) are not catered for in existing, entrenched political arrangements, their lack of lobbying power compounds the risk of resultant social exclusion. In addition to this, discrimination and prejudice at work or in society generally can intensify social exclusion. One recent study notes that 41% of foreign-born care workers in the UK report experiencing discrimination, prejudice or racist comments at work (Cangiano et al, 2009). These negative, exclusive experiences might persist alongside more objective challenges such as language barriers and unfamiliarity with cultural codes (Williams, 2007).

Migrant care workers in general are furthermore vulnerable to social exclusion due to certain aspects of their work-life arrangements. Europe-wide, jobs in the care sector are typically of lower quality with part-time work double that in the wider economy (31.6% versus 18.8% respectively) and temporary contracts in higher prevalence (12,7% versus 11.3%) (figures for 2009, European Commission, 2009: 17-19). Both these attributes are associated with higher in-work poverty (Eurofond, 2010). Care work is also characterised by atypical working patterns involving shift work and night hours, which can conspire to make a challenging work-life balance (Social Platform on Care, 2010). Furthermore, a significant gender imbalance exists in the caring workforce. Across the EU-27, over 78% of the health and social services workforce are female (Ibid). This makes the sector more prone to gender pay gaps, unequal treatment in terms of working time, leave, access to social security and health and safety provision. This can be traced

back to the conflation of care work with domestic, unpaid, feminised household labour which can make it an undervalued job in today's society.

And yet, as Williams (2010) underlines, migrant carers have the potential to forge great social cohesion; she states that 'Care sustains and repairs society. Without it there is no society'. For migrants themselves, good quality caring jobs could also represent 'stepping stones'. They might not require one's existing qualifications to be accredited, allowing newcomers to enter the labour market swiftly. They also provide exposure to the local language and experience of customs and norms in the new society (Williams, 2007; McGregor, 2007). Whether this potential is borne out in reality will be considered in light of some anecdotal evidence in Part III.

Part II: Care & Migration in combination across Europe

European care regimes take different forms and it is beyond the scope of this paper to discuss them all. Nonetheless, emerging similarities and potential for inclusion or exclusion of migrant care workers within European welfare states are being duplicated across the continent. One policy which is proliferating across the EU, for example, is Cash for Care. In brief this family of policies give the responsibility and cash resources to secure care labour in the home directly to the elderly or disabled person who needs it. It takes different forms in different national settings with governments formulating different provisos and limitations on its use.

In Italy, for example, Cash for Care implementation is subject to relatively low regulation and a culture of expecting caring labour to be cheap and available 24 hours a day persists from its established familiaristic welfare regime (Ungerson, 2004, Esping-Anderson, 1990). In this relatively grey area of the labour market, home-based care work funded (somewhat) by Cash for Care payments can be used to secure the cheap labour of undocumented migrants. Especially where these migrants are from disadvantaged sending countries, 'illegal', female and in need of accommodation, the offer of both work and lodging can be appealing. Yet Ungerson (2004) suggests that this situation can create an 'entrapment' for the migrant workers as the sector is poorly regulated for health and safety or working time directive compliance and building up formal work experience or documentation may prove elusive. Furthermore, working potentially day and night in private homes makes it harder to acquire social inclusion in wider society.

In Austria, the implementation of Cash for Care policies takes a different form. Care migrants are more likely to originate from neighbouring countries such as Slovakia, Slovenia or Hungary. Whilst they too work 24/7 in care-receivers' homes they are free to return home on a fortnightly basis for respite. This arrangement allows carers to 'work part-time, earn a reasonable income

and lead a transitional life between to economies and two homes' (Ungerson, 2004). Ungerson's interviews with workers in this situation have identified that this can promote a certain degree of social inclusion amongst this cadre of workers; the chance to learn German and maximise the purchasing power of wages earnt in the 'West' but spent in the 'East' can increase both their human capital and material assets.

Sweden in turn presents welfare state analysts with an alternative and dynamic example of new combinations of caring labour and immigration. Sweden has typically organised welfare, work and care 'based on principles of equality and solidarity' with the state proactively minimising social exclusion (Lyon and Glucksman, 2007). Yet, there is a growing role for the market in care provision and anecdotal evidence of migrants providing care in private homes in return for cash in hand is emerging (Ibid). Lyon and Glucksman (2007) note that this transition is often concealed, however, because of its tension with traditionally egalitarian policies. The taboo nature of this arrangement, therefore, could become socially exclusive to those migrants working in this emerging sector, despite working in one of Europe's traditionally most inclusive societies.

At the regional, macro-level East-West movements are being motored by the offer of payment for work in an industry which frequently (in domestic setting) does not demand rigorous or translatable credentialing. We are witnessing significant emigration from Eastern European and third countries to West which could create a 'brain and caring drain' in sending countries (Social Platform, 2010). The European Commission calculated that in 2009, 21.5 million people were employed in health and social services Europe-wide. Of those, over 19 million people (89%) work in the EU-15 while the remaining 2.3 million people (11%) work in EU-12 member states. As the EASPD (2010) posits, emigration of a significant part of the working-age population can perpetuate deteriorating social and family structures in the EU-12 and third countries and a care deficit where proportionately more people are in need of care and significantly fewer care-providers are present to assist them. Social exclusion increases among the elderly and/or disabled where their care needs are not adequately met, curtailing their ability to live full, healthy lives (Hildegard, 2005). Whilst the care deficit can be somewhat financially ameliorated through remittances sent by relatives working abroad, the absence of family members can be an especial handicap for those needing care in states which rely on the family for the majority of care provision as is predominant in Eastern Europe (Simonazzi, 2008).

Part III: UK Case Study

The UK Care Regime & Migration's Role

Reconciling work and care is a new social risk which has emerged in the recent decades for British families and especially women, as it has across Europe. Under conditions of (some) diminishing gender inequality, growing numbers of women have been entering the labour market. Concurrently, ageing population demographics are becoming increasingly apparent (Taylor-Gooby, 2004, Lewis et al, 2008). Analysts of the UK care sector predict that demand for care services will double by 2036 from current levels (Laing & Buisson, 2005). Whilst care by families and friends remains the predominant source of provision for the elderly (Cangiano et al, 2008), the UK has witnessed a marketization drive, particularly in the provision of institutional care which is reserved increasingly for the 'older-old' (80+ years) and those with the greatest need. Within the residential and nursing home sector, 92% of care places are now supplied by private and voluntary organisations with the NHS (National Health Service) and local authorities providing the remainder (Cangiano et al, 2008). The adult social care workforce is estimated to comprise 1.39million (top-level figure, 2006) and is projected to rise to 2.5million by 2025 (Skills for Care, 2005). McGregor (2007) observes that the sector has displayed increasing vacancy and turnover rates for health professionals, social workers, semi- and unskilled carers since the privatisation transition.

In order to fill the emerging deficit in carers for the elderly, the UK has taken a commodifying approach (Ungerson, 2004), and has become one of the 'largest importers of professional health care workers in the world' (Wanless et al, 2006:131; Lyon and Glucksmann, 2008). This is not a new phenomenon; international doctor and nurse NHS recruitment schemes have existed for many years (Redfoot and Houser 2005). Yet the experiences of migrant workers in the care sector (as opposed to more formal health sector) have been harder to document, given the increasingly fragmented, agency-run, privatised and sometimes informal nature of today's UK care industry.

The UK Migration Regime & Care's role

The UK's migration regime increasingly prioritises the immigration of skilled workers (Home Office White Paper, 2002; Redfoot and Houser 2005, Kofman and Raghuram, 2005). This stems from its intention to become a knowledge-based economy, capitalising on the globalising markets of research and development, particularly in science and engineering (OECD, 2002). The high-skills prioritisation policy has also been formulated in the context of political and public tensions regarding a perception of unwanted immigration; resulting in an increasingly sharp delineation being drawn between desired skilled migrants and undesired, so-called 'unskilled' migrants (Kofman and Raghuram, 2006, Bloch and Schuster, 2002). This has an intrinsic gender dimension (Ibid). Workers pursuing careers in science, IT and engineering (in which men are

over-represented) get categorised as highly-skilled, even if they have comparatively little work experience (Kofman and Raghuram, 2005). Simultaneously;

> 'the skills required in educational and caring jobs, such as teaching and nursing, are considered to be inherent in their femininity and often collapsed into it, so that these jobs are primarily conceptualised as women's jobs and therefore semi-skilled rather than skilled (Ibid, also Hardill and MacDonald, 2000).

Furthermore, again with most relevance to female migrants, Kofman and Raghuram (2005) underline the importance of differentiating between 'skilled migrants and skilled migration'. The latter, they argue, can occur without the attention of border authorities as women ('highly-skilled' according to their quality and quantity of education or professional experience) may enter as spouses, students or refugees (Iredale, 2005). Failure to gain recognition or accreditation of their skills often means that female migrants entering through these streams face challenges working in their original area of expertise. Subsequently, the caring industry, with its low- and semi-skilled label, has often become their only mode of entry to the labour market, prompting a cycle of deskilling (and indeed reskilling) for these workers (McGregor, 2007).

Migration's micro-motives are diverse and socially embedded; driven by a desire to materially improve the living standards of the migrant's family, realise the professional and empowerment aspirations of the individual, join social networks already established in the destination or escape adverse conditions, among other reasons (Doyle and Timonen, 2010; Portes and Böröcz 1989, Syed 2008). With its demanding physical and emotional elements, work in care is by all accounts, not an 'easy' environment in which to begin life in an unfamiliar country (Ungerson, 2004; Van der Geest et al, 2004) and migrant workers in this sector report a range of frustrations including racial discrimination, poor employment rights or training, difficulties reconciling personal care obligations and a sense of being overworked and undervalued (Cangiano et al 2008; Datta et al 2006, McGregor 2007).

Conversations with Carers: Empirical Research

As the above description of characteristics of the UK Care Industry suggests, much research has already been completed about the working lives of health workers – most often where they work in the more formalised NHS. A smaller body of research is growing involving care workers, and this is where this exploratory study fits. To date, eight research interviews have been conducted with migrant carers from South-East Asia; specifically the Philippines (5), Malaysia (1), India (1) and China (1). The interviewees work in an array of institutionalised care settings from NHS geriatric wards to private residential care homes. They are also located across the UK; including Glasgow, county centres and provincial towns. The informal interviews lasted between an hour

and ninety minutes and covered semi-structured topics inviting stories of migration, taking up work in care, using (or not using) existing qualifications, creating employment trajectories, wider experiences of living in the UK and their plans for the future. The following sections will group some of the emerging themes from these interviews firstly into descriptions of 'entrapments' and potential exclusion faced by these people in the labour market or wider society; and secondly into identification of 'stepping stones' whereby caring jobs enable migrants to make an entrée into UK society.

Entrapments: Migrant carers facing social exclusion

Entrapment 1: Work Permit Uncertainty

A recurring frustration described by the interviewees was the stress of enduring the demands of difficult caring jobs for their first five years in the UK before their work permit could be transformed into more secure residency or citizenship status. During this time, the loss of a job will mean the loss of a visa allowing them to stay in the UK. For this reason, migrant carers may be less likely to voice concerns about the pressures or unreasonable demands at work; a situation compounded by shyness which several interviewees associated with expectations from their home countries or simple unfamiliarity with the new environment. They may also take work which is not related to their existing training or which they do not feel comfortable doing. More pernicious, however, are reports from one interviewee which describe managers in one care home using the threat of firing staff to force them to accept pay which is under minimum wage (a particular burden when the worker is sending remittances home), undertake the least desirable tasks or shift schedule;

> '[D]uring my application for change of status I did not say anything to the manager, because they might block it. We were told by the management, 'I can call immigration to cancel your status' and that is worrying. 'I can call immigration and say that you are not working here, and if you are not working here anymore your visa will be considered invalid'. So while I am working, it is very tough I am feeling the pressure is too much, working very hard, applying for your visa, spending a lot of money, and that four months was really just a hell'
>
> *Joseph*[*]*, 39, Philippino, living in London for 6 years*.

Another carer, described frustration at the seeming impossibility of being promoted during her first five years, despite having qualified as a nurse seven years before emigrating;

[*]The names of all interviewees and their places of work have been altered.

> ‘[W]hen I moved to the Grampians, after two, three years you would expect they would [promote me], but nothing. There was this student who had just graduated and she became higher than us… Then, I didn’t have the courage to ask why because I felt when I was in the Grampians that I was very isolated, and I didn’t know my rights, plus I’m tied up in a work permit so I can’t do anything’.
>
> *Maria (40, Philippino, living in Scotland for 12 years),*

Other carers too commented on the discreet nature of this apparently discriminatory behaviour, with one Malaysian carer noting that her manager lost her application for a merit-related pay rise three times while the other British members of her team received their increases without challenge.

Entrapment 2: Racism

In addition to furtive racist behaviour, other carers described overt examples of racism both at work and in wider society. Maria lamented that her house has been attacked twice on what she believes are racial abuse grounds and that she hears racist comments from the residents at her work place ‘on an almost daily basis’. This threat from the local community makes her uncomfortable on public transport and in her neighbourhood. Another carer felt that racist sentiment from her manager created a ‘coldness’ between herself and the other non-migrant staff;

> ‘It lasted probably four years. And then there came to a point, where I tried to ignore it, I tried not to say anything because I would consider it disrespectful, but one day, she shouts at me, telling me ‘why don’t you go back to your country’ and all that kind of thing. We had an encounter one morning and I was working with another qualified nurse who is below her. We were just making beds, at that time you had to make them perfectly smooth, she had a go at me and my friend, that it wasn’t good enough, it was rubbish, and there were degrading words that I don’t want to say. The girl who was working with me is from Ghana’.
>
> *Arlene (51), Philippino, Living in a provincial, southern English town for 30 years*

An Indian male carer (Dan, 37, living in a county centre for 6 years) noted that abuse from residents in the care home is understandable (albeit not acceptable) as many suffer from dementia and are unhappy being out of their domestic comfort zones. He, two other male carers and Maria, however, all described fear that this frustration can manifest itself in racist ways if residents decide to report them to management on false accounts of abuse. Maria and another carer (Jose, *40, Phillipino, living near Glasgow for 10 years*) have both been reported and cleared of abuse charges which they believe were racially motivated. In Maria’s case, a related suspension meant a significant loss of income for several months which has put financial strain on her household. For

Jose, the incident made him lose trust in his colleagues and manager who did not investigate the allegation and instead threatened that the police would be coming to his home. This threat never materialised and the charges were eventually dropped. This racism therefore limits the carers' autonomy and confidence in the workplace and wider society. It is arguably socially exclusive.

Entrapment 3: Physical Work

A third recurring theme in the carers' stories which could indicate vulnerability to social exclusion is the physically demanding nature of the work. Many described it as 'back-breaking'. Joseph attributes his current twisted spine and possible need for surgery to four months spent in a care home with a particularly lax health and safety record. Jose noted that even though lifting equipment is typically available in the care home, it is rarely practical to take the time to go and bring it from a different ward, especially as the wards are almost always understaffed so there is constant time pressure. An (*35, Chinese, living near Glasgow for nine years*) described 'rushing everything' for her whole shift as there is never enough staff. All the carers interviewed work atypically long shifts compared to norms in the rest of society, none being shorter than 12 hours at a time. Sharon (*38, Philippino, living near Glasgow for 10 years*) regularly works 13 hour long shifts. The combination of the tiredness from this schedule, the understaffing and the impracticality of lifting equipment makes these workplaces particularly unsafe and back-pain was common among interviewees. If these injuries become debilitating, the workers could arguably be unable to sustain their livelihoods and the loss of income and mobility could be socially excluding. Most of the interviewees were planning on moving out of their jobs in the next 5 years and into less physically demanding jobs.

Stepping Stones: Migrant carers finding inclusion

Stepping Stone 1: Expanding horizons

For those carers with a background in medicine or healthcare, work in care homes can function as worthwhile acclimatisation work experience which allows them to gain clinical positions in hospitals and NHS establishments (which are often seen as more desirable as they have better worker protection, sick leave and pay arrangements). Initial care work placements allowed workers to get used to the 'lingo' and local accents (which can prove wildly different to those accents learnt at school in their countries of origin according to Dan, An, Arlene and Sharon).

For some of the carers, securing work in the UK allowed them to satisfy the desire to travel and escape more overbearing elements of their own families or culture. An, for example, felt young and curious when she left China; initially coming to the UK to enrol at an English school and support herself by working in a hospital as she had done in her early 20's. For Safiah (*58,*

Malaysian, Living in Glasgow for 40 years), it was the enjoyment of independence and not wanting to marry the man her family had chosen for her at home that made her persevere with qualifying to be a nurse in the UK. Both Jose and Dan observed that working in the UK allowed them to have an independent family life that was very important to them. Without the relatively higher wages that they could earn in the UK as opposed to in the Philippines or India, they would still be living with their parents (or in Dan's case, as a lone male migrant in Dubai, sending remittances home), unable to afford their own houses or cars.

Stepping Stone 2: Social Acceptance

A final characteristic of care work which carers found positive was the relationships they formed with residents and patients in the care homes. Perhaps a symptom of the intimate and compassionate nature of their work, many of the carers conceived of their responsibility to care for the elderly as though they were their own grandparents or relatives. Several carers described how residents remembered the birthdays of their children and liked to have visits from them in the care home. Others noted that they felt respected in society because of their profession and had good memories of the gratitude they received from the families of their patients when they had done a good job. Finally, some carers' social circle was predominantly composed of their colleagues - foreign-born and British alike – and they described these relationships as the thing they drew strength from when they went through difficult periods at work.

Conclusion

In conclusion, conversations with migrant care workers have revealed stories of care work functioning both as an entrapment and a stepping stone at different times and for different people. It is too early in the research to draw any clear conclusions on the circumstances which manifest to produce one outcome or another. It appears, however, that migrant workers are managing to transform entrapping work placements into stepping stones once they have acclimatised and, most notably, once they have completed their work permit time. Care work can persist as a trap of social exclusion when workers are particularly surrounded by colleagues, managers or patients who are racist and seemingly intent on sabotaging an upward work trajectory. Furthermore, work placements can leave lasting, exclusive mark on care workers' lives when health and safety provisions are inadequate and workers are insufficiently valued for the physical and mental exertion it takes to work in this sector. Nonetheless, certain care workers have expressed predominant positivity about their care work experiences. For some it has become a freeing experience, allowing them to enjoy family and social life more fully.

These insights are important to gather as care and migration interweave more commonly across Europe. The earlier parts of this paper noted that this phenomenon is becoming present in practically every EU nation. If we are to support our elderly sustainably without generating the social exclusion of a growing number of newcomers it will be necessary to ensure that care work functions as a stepping stone, rather than an entrapment of care workers. In the UK's particular case it will be vital to value the skills of caring work force better in both society and immigration procedures, improve their health and safety provisions at work and expel discriminatory behaviour. As the other brief examples from Italy, Austria and Sweden suggested, these actions will need to gel with existing care and welfare regimes, cultural expectations and policy structures in order to be successful. These efforts, nonetheless, will grow in value as our societies mature demographically and as we become host to increasing numbers of much needed caring labour.

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